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Part I

SALUS POPULI SUPREMA LEX ESTO

*"The welfare of the people shall be the supreme law."*



ROBIN CARNAHAN  
SECRETARY OF STATE

# MISSOURI REGISTER

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## IN THIS ISSUE:

### PART I

#### EMERGENCY RULES

##### Department of Revenue

Director of Revenue	.2455
Missouri Consolidated Health Care Plan	
Health Care Plan	.2455

#### PROPOSED RULES

##### Department of Natural Resources

Air Conservation Commission	.2520
Clean Water Commission	.2521

##### Department of Public Safety

Missouri Gaming Commission	.2687
----------------------------	-------

##### Department of Revenue

Director of Revenue	.2687
---------------------	-------

### PART II

##### Department of Corrections

State Board of Probation and Parole	.2695
-------------------------------------	-------

##### Elected Officials

Secretary of State	.2698
--------------------	-------

##### Department of Insurance, Financial Institutions and

##### Professional Registration

Missouri Board for Architects, Professional Engineers,	
Professional Land Surveyors, and Landscape Architects	.2701
State Board of Registration for the Healing Arts	.2703
Missouri Real Estate Commission	.2709

##### Missouri Consolidated Health Care Plan

Health Care Plan	.2711
------------------	-------

#### ORDERS OF RULEMAKING

##### Department of Agriculture

Weights and Measures	.2838
----------------------	-------

##### Department of Higher Education

Commissioner of Higher Education	.2840
----------------------------------	-------

##### Department of Public Safety

Missouri Gaming Commission	.2841
----------------------------	-------

##### Department of Social Services

MO HealthNet Division	.2841
-----------------------	-------

##### Retirement Systems

The Public School Retirement System of Missouri	.2849
---	-------

##### Department of Health and Senior Services

Missouri Board of Nursing Home Administrators	.2850
---	-------

##### Department of Insurance, Financial Institutions and

##### Professional Registration

Missouri State Board of Accountancy	.2856
Real Estate Appraisers	.2857

#### IN ADDITIONS

##### Department of Transportation

Missouri Highways and Transportation Commission	.2858
---	-------

##### Department of Health and Senior Services

Missouri Health Facilities Review Committee	.2859
---	-------

#### CONTRACTOR DEBARMENT LIST .2861

#### DISSOLUTIONS .2863

#### SOURCE GUIDES

##### RULE CHANGES SINCE UPDATE .2865

##### EMERGENCY RULES IN EFFECT .2879

##### EXECUTIVE ORDERS .2881

##### REGISTER INDEX .2884

Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
August 1, 2011 August 15, 2011	September 1, 2011 September 15, 2011	September 30, 2011 September 30, 2011	October 30, 2011 October 30, 2011
September 1, 2011 September 15, 2011	October 3, 2011 October 17, 2011	October 31, 2011 October 31, 2011	November 30, 2011 November 30, 2011
October 3, 2011 October 17, 2011	November 1, 2011 November 15, 2011	November 30, 2011 November 30, 2011	December 30, 2011 December 30, 2011
November 1, 2011 November 15, 2011	December 1, 2011 December 15, 2011	December 31, 2011 December 31, 2011	January 30, 2012 January 30, 2012
December 1, 2011 December 15, 2011	January 3, 2012 January 17, 2012	January 30, 2012 January 30, 2012	February 29, 2012 February 29, 2012
January 3, 2012 January 17, 2012	February 1, 2012 February 15, 2012	February 29, 2012 February 29, 2012	March 30, 2012 March 30, 2012
February 1, 2012 February 15, 2012	March 1, 2012 March 15, 2012	March 31, 2012 March 31, 2012	April 30, 2012 April 30, 2012

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at <http://www.sos.mo.gov/adrules/pubsched.asp>

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**RULES**—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 28, *Missouri Register*, page 27. The approved short form of citation is 28 MoReg 27.

The rules are codified in the *Code of State Regulations* in this system—

Title	Code of State Regulations	Division	Chapter	Rule
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

**RSMo**—The most recent version of the statute containing the section number and the date.

**R**ules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

**R**ules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

**A**ll emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

## Title 12—DEPARTMENT OF REVENUE Division 10—Director of Revenue Chapter 41—General Tax Provisions

### EMERGENCY AMENDMENT

**12 CSR 10-41.010 Annual Adjusted Rate of Interest.** The director proposes to amend section (1).

**PURPOSE:** Under the Annual Adjusted Rate of Interest (section 32.065, RSMo), this amendment establishes the 2012 annual adjusted rate of interest to be implemented and applied on taxes remaining unpaid during calendar year 2012.

**EMERGENCY STATEMENT:** The director of revenue is mandated to establish not later than October 22, an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year as set by the Board of Governors of the Federal Reserve rounded to the nearest full percent. This emergency amendment is necessary to ensure public awareness and to preserve a compelling governmental interest requiring an early effective date in that the amendment informs the public of the established rate of interest to be paid on unpaid amounts of taxes for the 2012 calendar year. A proposed amendment that covers the same material is published in this issue of the *Missouri Register*. The director has limited the scope of the emergency amendment to the circumstances creating the emergency. The director has followed procedures calculated to assure fairness to all interested persons and parties and has

complied with protections extended by the *Missouri* and *United States Constitutions*. This emergency amendment was filed October 24, 2011, becomes effective January 1, 2012, and expires June 28, 2012.

(1) Pursuant to section 32.065, RSMo, the director of revenue upon official notice of the average predominant prime rate quoted by commercial banks to large businesses, as determined and reported by the Board of Governors of the Federal Reserve System in the Federal Reserve Statistical Release H.15(519) for the month of September of each year has set by administrative order the annual adjusted rate of interest to be paid on unpaid amounts of taxes during the succeeding calendar year as follows:

Calendar Year	Rate of Interest on Unpaid Amounts of Taxes
1995	12%
1996	9%
1997	8%
1998	9%
1999	8%
2000	8%
2001	10%
2002	6%
2003	5%
2004	4%
2005	5%
2006	7%
2007	8%
2008	8%
2009	5%
2010	3%
2011	3%
2012	3%

**AUTHORITY:** section 32.065, RSMo 2000. Emergency rule filed Oct. 13, 1982, effective Oct. 23, 1982, expired Feb. 19, 1983. Original rule filed Nov. 5, 1982, effective Feb. 11, 1983. For intervening history, please consult the *Code of State Regulations*. Emergency amendment filed Oct. 24, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the *Missouri Register*.

## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

### EMERGENCY AMENDMENT

**22 CSR 10-2.010 Definitions.** The Missouri Consolidated Health Care Plan is deleting sections (6), (8), (9), (11), (13), (16), (19), (21), (22), (24)–(26), (29)–(32), (34), (36), (39), (42), (47), (50), (51), (53), (56)–(59), (62), (63), (65)–(67), (71), (75), (78)–(81), (83)–(86), (88)–(90), (93), (96), (99)–(104), (106), (109)–(111), (113), (114), (122), (123), (126), (127), (129), and (132)–(134); amending sections (1), (3)–(5), (9), (10), (14), (18), (23), (27), (28), (33), (37), (38), (40), (41), (43)–(46), (48), (52), (54), (55), (60), (70), (72), (73), (77), (82), (87), (94), (97), (98), (105), (112), (117), (119), (120), (124), (128), and (131); adding sections (9), (22), (24), (30), (45), (47), (56), (71), (73), and (74); and renumbering as necessary.

**PURPOSE:** *This amendment changes the policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan relative to state members.*

**EMERGENCY STATEMENT:** *This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) **Accident.** An unforeseen and unavoidable event resulting in an injury [which is not due to any fault or misconduct on the part of the person injured].

(3) **Administrative appeal.** A written request submitted by or on behalf of a member involving [Missouri Consolidated Health Care Plan (MCHCP)] **plan-related** administrative issues such as eligibility, effective dates of coverage, **and** plan changes[, etc].

(4) **Adverse benefit determination.** [When the claims administrator reviews an admission, availability of care, continued stay, or other health care service and decides that it is not medically necessary, appropriate, or effective. Therefore, payment for the requested service is denied, reduced, or terminated.] An adverse benefit determination means any of the following:

(A) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit based on a determination of an individual's eligibility to participate in the plan;

(B) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, or a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, investigational, or not medically necessary or appropriate; or

(C) Rescission of coverage after an individual has been covered under the plan.

(5) **Allowable [expense] amount.** [Charges for services rendered or supplies furnished by a health plan that would qualify as covered expenses and for which the program pays in whole or in part, subject to any deductible and coinsurance

amounts.] **Maximum amount on which payment is based for covered health care services.** This may be called eligible expense, payment allowance, or negotiated rate. If the provider charges more than the allowed amount, the member may be balance-billed. See balance billing, section (7).

[(6) **Appeal.** A written complaint submitted by or on behalf of a member regarding one (1) of the following:

(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claim payment, handling, or reimbursement for pharmacy benefits or health care services.]

[(7)](6) **Applied behavior analysis.** The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior.

[(8) **Assignment.** When a doctor agrees to accept Medicare's fee as full payment.]

[(9) **Benefit period.** The three hundred sixty-five (365) days immediately after the first date of services to treat a given condition.]

(7) **Balance billing.** When a provider bills for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is one hundred dollars (\$100) and the allowed amount is seventy dollars (\$70), the provider may bill the member for the remaining thirty dollars (\$30). A network provider may not balance bill.

[(10)](8) **Benefits.** [Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator.] **Health care services covered by the plan.**

[(11) **Birthday rule.** If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.]

[(12)](9) **Board.** The board of trustees of the Missouri Consolidated Health Care Plan (MCHCP).

[(13) **Calendar year.** The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.]

[(14)](10) **Cancellation of coverage.** The [voluntary cancellation] ending of medical, dental, or vision coverage per a subscriber's voluntary request.

[(15)](11) **Case management.** A coordinated set of activities conducted for individual patient management of serious or complicated health conditions.

[(16) **Chiropractic services.** The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health.]

[(17)](12) Claims administrator. An organization or group responsible for the processing of claims and associated services for a health plan.

[(18)](13) Coinsurance. *[The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.]* The member's share of the costs of a covered health care service, calculated as a percent (for example, twenty percent (20%)) of the allowed amount for the service. The member pays coinsurance plus any deductibles owed. For example, if the health insurance or plan's allowed amount for an office visit is one hundred dollars (\$100) and the member has met his/her deductible, the member's coinsurance payment of twenty percent (20%) would be twenty dollars (\$20). The health insurance or plan pays the rest of the allowed amount.

[(19)] Comprehensive major medical. A plan that provides for cost sharing to be applied to all covered expenses, such as deductible or coinsurance.]

[(20)](14) Congenital defect. Existing or dating from birth. Acquired through development while in the uterus.

[(21)] Convenient care clinics (CCCs). Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics."

[(22)] Coordination of benefits. Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.]

[(23)](15) Copayment. *[A set dollar amount that the covered individual must pay for specific services.]* A fixed amount, for example, fifteen dollars (\$15) the member pays for a covered health care service, usually when the member receives the service. The amount can vary by the type of covered health care service.

[(24)] Cosmetic surgery. A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than restore the anatomy and/or functions of the body which are lost or impaired due to illness or injury.

[(25)] Covered benefits and charges. Covered benefits are a schedule of health care services payable under the plan. Covered charges are the cost for medical services eligible for consideration under the plan.

[(26)] Custodial care. Services and supplies furnished primarily to assist an individual to meet the activities of daily living that can be provided by persons without the training of a health care provider or that do not entail and require the continuing attention of trained medical or paramedical personnel.]

[(27)](16) Date of service. Date medical services are received *[or performed]*.

[(28)](17) Deductible. *[The amount of expense the member must pay before the plan begins to pay for covered services and supplies. This amount is not reimbursable by the plan.]* The amount the member owes for health care services that the health plan covers before the member's health plan begins to pay. For example, if the deductible is one thousand dollars (\$1,000), the member's plan will not pay anything until s/he meets his/her

one thousand dollars (\$1,000) deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

[(29)] Dependent child. Any child under the age of twenty-six (26) that is a natural child, legally adopted or placed for adoption child, or a child with one (1) of the following legal relationships with the member, so long as such legal relationship remains in effect:

(A) Stepchild;

(B) Foster child;

(C) Grandchild for whom the employee has legal guardianship or legal custody; and

(D) Other child for whom the employee is the court-ordered legal guardian.

1. Except for a disabled child as described in 22 CSR 10-2.010(89), a dependent child is eligible from his/her eligibility date to the end of the month he/she attains age twenty-six (26) (see paragraph 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child beyond age twenty-six (26)).

2. A child who is a dependent child under a guardianship of a minor will continue to be a dependent child when the guardianship ends by operation of law when the child becomes eighteen (18) years of age if such child was an MCHCP member the day before the child becomes eighteen (18) years of age.

[(30)] Dependents. The lawful spouse of the employee, the employee's child(ren), and certain survivors of employees, as provided in the plan document and these rules, for whom enrollment has been made and has been accepted for participation in the plan.

[(31)] Diagnostic. Describes a procedure to determine whether a person has a particular illness.

[(32)] Diagnostic charges. The Usual, Customary, and Reasonable (UCR) charges or the network discounted rate (NDR) for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.]

[(33)](18) Disease management. A program offered to *[non-Medicare]* members, who do not have primary Medicare coverage, to help manage certain chronic diseases.

[(34)] Disposable supplies. Supplies that do not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.]

[(35)](19) Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:

(A) Doctor of medicine;

(B) Doctor of osteopathy;

(C) Podiatrist;

(D) Optometrist;

(E) Chiropractor;

(F) Psychiatrist;

(G) Psychologist;

(H) Doctor of dental medicine, including dental surgery;

(I) Doctor of dentistry; or

(J) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

[(36)] Durable medical equipment (DME). Equipment able to withstand repeated use for the therapeutic treatment of an

*active illness or injury. Such equipment is not covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.]*

**(20) Effective date.** The date on which coverage takes effect as described in 22 CSR 10-2.020(4).

**[(37)](21) Eligibility date.** The first day a member is qualified to enroll for coverage [A/as described in 22 CSR 10-2.020(2)].

**(22) Eligibility period.** The time allowed to enroll in accordance with the rules in this chapter.

**[(38)](23) Emergency medical condition.** *[A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—*

*(A) Conditions placing a person's health in significant jeopardy;*

*(B) Serious impairment to a bodily function;*

*(C) Serious dysfunction of any bodily organ or part;*

*(D) Inadequately controlled pain; or*

*(E) Situations when the health of a pregnant woman or her unborn child are threatened.] The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:*

*(A) Placing a person's health in significant jeopardy;*

*(B) Serious impairment to a bodily function;*

*(C) Serious dysfunction of any bodily organ or part;*

*(D) Inadequately controlled pain; or*

*(E) With respect to a pregnant woman who is having contractions—*

*1. That there is inadequate time to effect a safe transfer to another hospital before delivery; or*

*2. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.*

**[(39) Emergency room.** *The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.]*

**[(40)](24) Emergency Services.** With respect to an emergency medical condition—

*(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluate such emergency medical condition; and*

*(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient. The term "to stabilize" means to provide such medical treatment of the condition as may be necessary to [assure] ensure, within reasonable medical probability that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility.*

**[(41)](25) Employee.** A **benefit-eligible** person employed by the state and present and future retirees from state employment who meet the **plan** eligibility requirements *[as prescribed by law]*.

**[(42) Employee and dependent participation.** *Participation of an employee and the employee's eligible dependents. Any*

*individual eligible for participation as an employee is eligible as a dependent up to the age of twenty-six (26), except as noted in 22 CSR 10-2.020(1)(A)3.]*

**[(43)](26) Employer.** The state department or agency that employs the eligible employee *[as defined above]*.

**[(44)](27) Essential benefits.** The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

*(A) Ambulatory patient services—office visits, urgent care, outpatient diagnostic procedures, outpatient surgery, and outpatient hospice;*

*(B) Emergency services—ambulance services and emergency room services;*

*(C) Hospitalization—inpatient hospital benefits, inpatient surgery, transplants, and inpatient hospice;*

*(D) Maternity and newborn care—maternity coverage and newborn screenings;*

*(E) Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/chemical dependency office visits;*

*(F) Prescription drugs;*

*(G) Rehabilitative and habilitative services and devices—durable medical equipment; cardiac and pulmonary rehabilitation; outpatient physical, speech, and occupational therapy; and home health care/[palliative services];*

*(H) Laboratory services—lab and [x/X-ray];*

*(I) Preventive and wellness services and chronic disease management; and*

*(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, immunizations, preventive services, and newborn screenings.*

**(28) Excluded services.** Health care services that the member's health plan does not pay for or cover.

**[(45)](29) Executive director.** The chief executive officer of the Missouri Consolidated Health Care Plan (MCHCP), who shall have charge of the offices, records, and employees of the plan, subject to the direction of the board of trustees.

**[(46)](30) Experimental/Investigational/Unproven.** A treatment, procedure, device, or drug that meets any of the criteria listed below **and that the plan administrator determines, in the exercise of its discretion,** is considered experimental/investigational/unproven and is not eligible for coverage under the plan. *Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community. Experimental/investigational/unproven is defined as a treatment, procedure, device, or drug that the plan administrator determines, in the exercise of its discretion]—*

*(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;*

*(B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or*

*(C) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis.*



**(D) Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.**

*[(47)] First eligible. The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first eligibility period is the first thirty-one (31) days from the date of the life event.]*

*[(48)](31) Formulary. A list of U.S. Food and Drug Administration approved drugs [covered] and supplies developed by the pharmacy benefit manager and [as allowed] covered by the plan administrator.*

*[(49)](32) Generic drug. The chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.*

*[(50)] Group health plan. A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.*

*(51) Handbook. The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference is available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2011 State Member Handbook (March 15, 2011) or online at [www.mchcp.org](http://www.mchcp.org). It does not include any later amendments or additions.]*

*[(52)](33) Health assessment (HA). A questionnaire about a member's health and lifestyle habits required for participation in the [wellness] Lifestyle Ladder program.*

*[(53)] Health care benefit. Coverage under the plan to include medical, dental, vision, and pharmacy.]*

*[(54)](34) Health savings account (HSA). A tax-advantaged savings account that may be used to pay for current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. [HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.]*

*[(55)](35) High Deductible Health Plan (HDHP). A health plan with a higher deductible/s than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.*

*[(56)] Home health care. Skilled nursing services and other therapeutic services to persons in their homes provided by an agency certified by Medicare and licensed pursuant to state or local law.*

*(57) Hospice. A public agency, private organization, or a subdivision of either that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.*

*(58) Hospice facility. A public or private organization, certified by Medicare and any other state's licensing or certifying body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility or part thereof which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.*

*(59) Hospital.*

*(A) An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic, and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24)-hour-a-day nursing service by a registered nurse (RN) on duty or call.*

*(B) An institution not meeting all the requirements of subsection (59)(A) above, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.*

*(C) An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).*

*(D) A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.*

*(E) A residential alcoholism, chemical dependency, or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction.*

*(F) In no event shall the term hospital include a skilled nursing facility or any institution or part thereof which is used primarily as a skilled nursing facility, nursing home, rest home, or facility for the aged.]*

*[(60)](36) Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered [as any other] an illness.*

*[(61)](37) Incident. A definite and separate occurrence of a condition.*

*[(62)] Infertility. Any medical condition causing the inability or diminished ability to reproduce.*

*(63) Infertility services. Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.]*

*[(64)](38) Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.*

*[(65)] Inpatient. Confined to a registered bed. Patient in hospital, skilled nursing facility, hospice facility, or free-standing chemical dependency treatment center.*

*(66) Life events. Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.*

*(67) Lifestyle Ladder. MCHCP's wellness program.]*

*[(68)](39) Lifetime maximum. The amount payable by a medical plan during a covered member's life for specific non-essential benefits.*

**[(69)](40) MCHCPid.** An individual MCHCP member identifier used for member verification and validation.

**[(70)](41) myMCHCP.** A secure MCHCP member website that *[includes coverage selection, level of coverage, an option to change a mailing address, an option to add or change an email address, an option to request an MCHCPid card, and access to other pertinent websites]* allows members to review coverage selections, verify covered dependents, make coverage changes, add/change email address, and access health plan websites.

**[(71) Medical benefits coverage.** Services that are received from providers recognized by the plan and are covered benefits under the plan.]

**[(72)](42) Medically necessary.** Treatments, procedures, services, or supplies that the plan administrator determines, in the exercise of its discretion—

(A) Are expected to be of clear clinical benefit to the patient; and

(B) Are appropriate for the care and treatment of the injury or illness in question; and

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.

**[(73)](43) Medicare-approved amount.** The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a *[doctor or]* health care provider.

**(44) Medicare assignment.** When a health care provider agrees to accept the Medicare-approved amount as payment in full for claims.

**[(74)](45) Member.** Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

**[(75) Network provider.** A physician, hospital, pharmacy, or other health provider that is contracted with the plan or its designee.]

**(46) Network.** The facilities, providers, and suppliers the health insurer or plan has contracted with to provide health care services.

**[(76)](47) Non-formulary.** A drug not contained on the pharmacy benefit manager's list of covered drugs.

**[(77)](48) Non-network *[provider or non-participating provider.*** A physician, hospital, pharmacy, or other health provider that does not have a contract with the plan or its designee]. **The facilities, providers, and suppliers the health plan does not contract with to provide health care services.**

**[(78) Nurse.** A registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule.

**(79) Nursing home.** An institution operated, pursuant to law, primarily for custodial care or for patients recovering from illness or injury, under the supervision of a physician or registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations that are recognized under Medicare.

**(80) Open enrollment period.** A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year.

**(81) Out-of-area.** Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria.]

**[(82)](49) Out-of-pocket maximum.** *[The annual limit on the amount a member must pay for covered services. Above this limit, the medical plan pays one hundred percent (100%) for covered services for the rest of the plan year.]* **The most the member will pay during a plan year before the plan begins to pay one hundred percent (100%) of the allowed amount. This limit never includes the member's premium, copayments, balance-billed charges, or health care services the plan does not cover.**

**[(83) Outpatient.** Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.

**(84) Outpatient observation stay.** Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.

**(85) Palliative services.** Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

**(86) Partial hospitalization.** A distinct and organized intensive ambulatory treatment service, less than twenty-four (24)-hour daily care specifically designed for the diagnosis and active treatment of a mental/nervous disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

(A) Partial hospitalization programs must provide diagnostic services; services of social workers; nurses and staff trained to work with psychiatric patients; individual, group, and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions.

(B) The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a physician.]

*[(87)](50) Participant. [Any employee or dependent accepted for membership in the plan.] Shall have the same meaning as the term member defined herein. See member, section (45).*

*[(88) Pharmacy benefit manager (PBM). The PBM designs, implements, and manages the overall drug benefit of the plan and processes claims payments.*

*(89) Physically or mentally disabled. A person's inability to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition.*

*(90) Physician/Doctor. A licensed practitioner of the healing arts, acting within the scope of his/her practice, as licensed under section 334.021, RSMo.]*

*[(91)](51) Plan. The program of health care benefits established by the board of trustees of the Missouri Consolidated Health Care Plan as authorized by state law.*

*[(92)](52) Plan administrator. The board of trustees of the Missouri Consolidated Health Care Plan, which is the sole fiduciary of the plan. The board has all discretionary authority to interpret its provisions and to control the operation and administration of the plan and whose decisions are final and binding on all parties.*

*[(93) Plan document. The statement of the terms and conditions of the plan as promulgated by the plan administrator in this chapter.]*

*[(94)](53) Plan year. The [calendar year beginning] period of January 1 through December 31. [This is the period during which the total amount of annual benefits is calculated. All deductibles and benefit maximums accumulate during the calendar year.]*

*[(95)](54) Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to plan members. Benefits are paid at a higher level when network providers are used.*

**(55) Premium. The monthly amount that must be paid for health insurance.**

*[(96) Preventive service. A procedure intended for avoidance or early detection of an illness.]*

*[(97)](56) Primary care physician (PCP). [A physician (usually a)An internist, family/general practitioner, or pediatrician/] who has contracted with a medical plan].*

*[(98)](57) Prior authorization. [A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service. Also known as pre-authorization or pre-notification.] A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called pre-authorization, prior approval, or precertification. The plan may require prior authorization for certain services before the member receives them, except in an emergency. Prior authorization is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request prior authorization.*

*[(99) Private duty nursing. Nursing care on a full-time basis in the member's home or home health aides.*

*(100) Proof of eligibility. Documentation required by the plan to determine a dependent's qualification for health insurance coverage.*

*(101) Proof of prior group insurance. Evidence in written form from an insurance company that provides verification of coverage for a given period of time.*

*(102) Proof of prior group coverage. If a member or his/her dependents enroll in the plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:*

- (A) Date coverage was or will be terminated;*
- (B) Reason for coverage termination; and*
- (C) List of dependents covered.*

*(103) Prostheses. An artificial extension that replaces a missing part of the body or supplements defective parts.*

*(104) Protected health information (PHI). Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.]*

*[(105)](58) Provider. A physician, hospital, medical agency, specialist, or other duly/- licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2.010/(35)/(19). Other providers include but are not limited to:*

- (A) Audiologist (AUD or PhD);*
- (B) Certified Addiction Counselor for Substance Abuse (CAC);*
- (C) Certified Nurse Midwife (CNM)—when acting within the scope of [their] his/her license in the state in which [they] s/he practices and performing a service which would be payable under this plan when performed by a physician;*
- (D) Certified Social Worker or Masters in Social Work (MSW);*
- (E) Chiropractor;**
- [(E)](F) Licensed Clinical Social Worker;*
- [(F)](G) Licensed Professional Counselor (LPC);*
- [(G)](H) Licensed Psychologist (LP);*
- [(H)](I) Nurse Practitioner (NP);*
- [(I)](J) Physician/s] Assistant (PA);*
- [(J)](K) [Qualified] Occupational Therapist;*
- [(K)](L) [Qualified] Physical Therapist;*
- [(L)](M) [Qualified] Speech Therapist;*
- [(M)](N) Registered Nurse Anesthetist (CRNA);*
- [(N)](O) Registered Nurse Practitioner (ARNP); or*
- [(O)](P) Therapist with a PhD or Master's Degree in Psychiatry or related field.*

*[(106) Provider directory. A listing of network providers within a health plan.]*

*[(107)](59) Prudent layperson. An individual possessing an average knowledge of health and medicine.*

*[(108)](60) Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or member if the plan normally provides coverage for dependent children.*

*[(109) Reconstructive surgery. A procedure performed to restore the anatomy and/or functions of the body that are lost or impaired due to an injury or illness.*

*[(110) Refractions. A record of the patient's preference for the focusing of the eyes that may then be used to purchase eyeglasses or contact lenses. It is the part of the exam that determines what prescription lens gives the patient the best possible vision.*

*[(111) Rehabilitation facility. A legally operating institution, or distinct part of an institution, that has a transfer agreement with one (1) or more hospitals and is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital, and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services.*

*(A) It does not include institutions that provide only minimal care, custodial care, ambulatory or part-time care services, or an institution that primarily provides treatment of mental/nervous disorders, substance abuse, or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission for the Accreditation of Rehabilitation Facilities.]*

*[(112)](61) Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-2.020/(7)(B)](2)(D) and is currently receiving a monthly retirement benefit from a retirement system listed in such rule.*

*[(113) Skilled nursing care. Services that must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.*

*[(114) Skilled nursing facility (SNF). A public or private facility licensed and operated according to the law that provides—*

*(A) Permanent and full-time facilities for ten (10) or more resident patients;*

*(B) A registered nurse or physician on full-time duty in charge of patient care;*

*(C) At least one (1) registered nurse or licensed practical nurse on duty at all times;*

*(D) A daily medical record for each patient;*

*(E) Transfer arrangements with a hospital; and*

*(F) A utilization review plan.*

*The facility must be primarily engaged in providing continuous skilled nursing care for persons during the recovery stage of their illness or injury, and is not, other than by coincidence, a rest home for custodial care or for the aged.]*

*[(115)](62) Sound natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.*

*[(116)](63) Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.*

*[(117)](64) Specialty medications. High cost drugs that [are primarily self-injectible; sometimes oral medications] treat*

*chronic complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis.*

*[(118)](65) State. Missouri.*

*[(119)](66) Step therapy. Designed to encourage use of therapeutically[-] equivalent, lower-cost alternatives before using more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.*

*[(120)](67) Subrogation. The substitution of one (1) "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the [participant] member and recover the money directly from the other insurer.*

*[(121)](68) Subscriber. The employee or member who elects coverage under the plan.*

*[(122) Surgery. Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.*

*[(123) Surgery center (ambulatory). A hospital-based, hospital-sponsored, or independently-owned facility that performs surgery.]*

*[(124)](69) Survivor. A member who meets the requirements of subsection 22 CSR 10-2.020/(7)(A)](2)(D).*

**(70) Terminated vested subscriber. A member who meets the requirements of subsection 22 CSR 10-2.020(2)(D).**

*[(125)](71) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.*

**(72) Tobacco. Cigarettes, cigarette papers, clove cigarettes, cigars, smokeless tobacco, smoking tobacco, other form of tobacco products, or products made with tobacco substitute containing nicotine.**

**(73) Tobacco-free. A member has not used a tobacco product in at least the previous three (3) months and plans to remain tobacco-free in the future.**

*[(126) Urgent care. Medically necessary services in order to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.*

*[(127) Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.]*

**[(128)](74) Usual, [C]customary, and [R]reasonable [charge]. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.**

[(A) Usual. The fee a provider most frequently charges the majority of his/her patients for the same or similar services.

(B) Customary. The range of fees charged in a geographic area by providers of comparable skills and qualifications for the same performance of similar service.

(C) Reasonable. The flexibility to take into account any unusual clinical circumstances involved in performing a particular service.

(D) A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the providers for ninety percent (90%) of the procedures reported.

(129) Utilization review. Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a prospective, concurrent, or retrospective basis.]

[(130)](75) Vendor. The current applicable third-party administrators of MCHCP benefits.

[(131)](76) Vested subscriber. A member who meets the requirements of subsection 22 CSR 10-2.020[(7)(B)](2)(D).

[(132) Wellness participation year. Year in which members may participate in the wellness program per plan year: October 1–September 25.

(133) Wellness program. A voluntary program focusing on awareness, health education, and behavior change.

(134) Wellness premium. The monthly medical premium applied to members who successfully complete all requirements of the Lifestyle Ladder program.]

**AUTHORITY:** section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the *Code of State Regulations*. Emergency amendment filed Nov 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the *Missouri Register*.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership  
EMERGENCY RESCISSION**

**22 CSR 10-2.020 General Membership Provisions.** This rule established the policy of the board of trustees in regard to the General Membership Provisions of the Missouri Consolidated Health Care Plan.

**PURPOSE:** This rule is being rescinded and readopted to include detailed language to clarify general membership provisions.

**EMERGENCY STATEMENT:** This emergency rescission must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rescission is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for

reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the *Missouri Register*. This emergency rescission complies with the protections extended by the *Missouri* and *United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.

**AUTHORITY:** section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the *Code of State Regulations*. Emergency rescission filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rescission covering this same material is published in this issue of the *Missouri Register*.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY RULE**

**22 CSR 10-2.020 General Membership Provisions**

**PURPOSE:** This rule establishes the policy of the board of trustees in regard to the general membership provisions of the Missouri Consolidated Health Care Plan.

**EMERGENCY STATEMENT:** This emergency rule must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the

**Missouri Register.** This emergency rule complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.

(1) Terms and Conditions. The following rules provide the terms and conditions for membership in the Missouri Consolidated Health Care Plan (MCHCP). Members are required to provide complete, true, and accurate information to MCHCP in connection with enrollment, change, or cancellation processes, whether by online, written, or verbal communication. MCHCP may rely on, but reserves the right to audit, any information provided by members and seek recovery and/or pursue legal action to the extent members have provided incomplete, false, or inaccurate information.

(2) Eligibility Requirements.

(A) Employee Eligibility Requirements.

1. An employee may enroll in one (1) of MCHCP's plans if s/he meets the following criteria:

A. A state employee whose position is covered by the Missouri State Employees' Retirement System (MOSERS) and not covered under another retirement or benefit plan supported by state contributions or a member of the Public School Retirement System (PSRS) and employed by a state agency.

2. An employee cannot be covered as an employee and as a dependent.

(B) Dependent Eligibility Requirements.

1. An employee who is not retired may enroll eligible dependents as long as the employee is also enrolled. Eligible dependents include:

A. Spouse.

(I) If both spouses are state employees covered by MCHCP, each spouse must enroll separately.

(II) State employees eligible for coverage under the Missouri Department of Transportation, Department of Conservation, or the Highway Patrol medical plans may not enroll as a spouse under MCHCP.

(III) A state retiree may enroll as a spouse under an employee's coverage or elect coverage as a retiree.

(IV) If one spouse is a state employee with MCHCP benefits and the other is a public entity employee with MCHCP benefits, each spouse may enroll under his or her employer's plan or together under one employer's plan. The spouses cannot have coverage in both places; and

B. Children.

(I) Children may be covered through the end of the month in which they turn twenty-six (26), if they meet one (1) of the following criteria:

- (a) Natural child of subscriber or spouse;
- (b) Legally adopted child of subscriber or spouse;
- (c) Child legally placed for adoption of subscriber or spouse;

(d) Stepchild of subscriber or spouse;

(e) Foster child of subscriber or spouse;

(f) Grandchild for whom the covered subscriber or covered spouse has legal guardianship or legal custody;

(g) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years of age if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years of age;

(h) Newborn of a subscriber or a covered dependent;

(i) Child for whom the subscriber or covered spouse is

required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or

(j) Child who is twenty-six (26) or older and is permanently disabled in accordance with subsection (5)(C), only if such child was an MCHCP member the day before the child turned twenty-six (26).

(II) A child may only be covered by one (1) parent if his/her parents are married and are both covered under an MCHCP medical plan.

(III) A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. MCHCP will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time.

(C) Changes in Dependent Status. If a covered dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days to terminate his/her coverage effective the end of the month eligibility ceases.

(D) Retiree, Survivor, Vested, Terminated Vested, and Long-Term Disability Employee; Elected State Officials and their Employee; and Dependent Eligibility Requirements.

1. An employee may participate in an MCHCP plan when s/he retires if s/he is eligible to receive a monthly retirement benefit from either MOSERS or from PSRS for state employment.

A. To enroll or continue coverage at retirement, the employee and his/her dependents must provide all of the following:

(I) Submit a completed enrollment form within thirty-one (31) days of retirement date. Coverage is effective on retirement date;

(II) Submit a completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last two payrolls and the option to pre-pay premiums through the cafeteria plan;

(III) Submit proof of prior coverage and proof of eligibility for dependents if s/he and his/her dependents choose to enroll in an MCHCP plan at retirement and have had other insurance coverage for six (6) months immediately prior to his/her retirement; and

(IV) Submit a statement from PSRS that indicates the effective date of the subscriber's retirement if the subscriber is a PSRS retiree.

B. Employees may continue coverage on their eligible dependents into retirement.

C. If the employee's spouse is a state employee (active or retired), s/he may transfer coverage under the plan in which his/her spouse is enrolled or from his/her spouse's coverage to his/her own coverage at any time as long as both spouses are eligible for MCHCP coverage and their coverage is continuous.

2. An enrolled terminated vested or long-term disability employee and his/her dependents will have continuous coverage into retirement unless the member submits a termination form.

3. A survivor of an active employee who is a vested subscriber and his/her dependents or a survivor of a vested subscriber who was receiving long-term disability benefits and his/her dependents from MOSERS or PSRS may continue coverage if the survivor had—

A. Coverage through MCHCP at the time of the subscriber's death; or

B. Other health insurance for the six (6) months immediately prior to employee's death. Proof of eligibility for each dependent, proof of prior group coverage (letter from previous insurance carrier

or former employer with dates of effective coverage), and a list of dependents covered is required.

4. A survivor of a retired employee or long-term disability recipient may continue coverage if the survivor was covered at the time of the employee's death.

5. An employee may participate in an MCHCP plan when his/her employment with the state terminates if s/he is a vested member and is eligible for a future benefit from the MOSERS or PSRS as a state employee when s/he reaches retirement age. The employee must elect to continue coverage within thirty-one (31) days from the last day of the month in which his/her employment is terminated.

A. If a vested employee's spouse is a state employee (active or retired), the vested employee may transfer coverage under the plan in which his/her spouse is enrolled.

B. The employee and his/her dependents must meet one (1) of the following requirements to participate in an MCHCP plan as a terminated vested employee:

(I) Coverage through MCHCP since the effective date of the last open enrollment period; or

(II) Proof of prior group coverage for the six (6) months immediately prior to the termination of state employment. Proof of prior group coverage (letter from previous insurance carrier or former employer with dates of effective coverage) and list of dependents covered is required.

6. If a vested employee does not elect coverage, or if s/he cancels his/her coverage or dependent coverage, the vested employee and his/her dependents cannot enroll at a later date. The vested employee may continue coverage under the provisions of Consolidated Omnibus Budget Reconciliation Act (COBRA).

7. If any retired, survivor, terminated vested, or long-term disability employee, or his/her dependents who are eligible for coverage, elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage except as noted in paragraph (2)(D)8.

8. A long-term disability employee must be eligible for long-term disability benefits from MOSERS or PSRS and have had coverage since the effective date of the last open enrollment period.

A. The employee may continue coverage on his/her dependents or add new dependents due to a life event.

B. If the employee becomes ineligible for disability benefits, the employee and his/her dependents may continue coverage as applicable, as a terminated vested, retired, or COBRA subscriber, unless the employee returns to active state employment.

C. If coverage was not elected through MCHCP before the date of disability, the employee and his/her dependents may enroll as long as the employee and his/her dependents have had other health insurance coverage for the six (6) months immediately prior to the employee's disability. Proof of eligibility for each dependent and proof of prior group coverage (letter from previous insurance carrier or former employer with dates of effective coverage) and a list of dependents covered is required.

D. If coverage was not maintained while on disability, the employee and his/her dependents may enroll on the date the employee is eligible for retirement benefits as long as the employee and his/her dependents have had other health insurance coverage for the six (6) months immediately prior to the employee's retirement. Proof of eligibility for each dependent and proof of prior group coverage (letter from previous insurance carrier or former employer with dates of effective coverage) and a list of dependents covered is required.

E. If the employee's spouse is a state employee (active or retired), s/he may transfer coverage under the plan in which his/her spouse is enrolled.

F. If the employee wishes to be covered individually at a later date, s/he can make the change, as long as coverage is continuous.

G. If the employee returns to work, the employee and his/her state employee spouse must be covered individually.

9. A retiree, survivor, vested employee, or long-term disability

employee and/or his/her dependents may continue dental and/or vision coverage into retirement without medical coverage.

10. An elected state official or his/her employees may continue coverage in an MCHCP plan if s/he is a member of the General Assembly, a state official holding a statewide office, or employed by a member of the General Assembly or a state official and his/her employment terminates because the state official or member of the General Assembly ceases to hold elected office. The elected state official or his/her employees must elect to continue coverage within thirty-one (31) days from the last day of the month in which his/her employment is terminated. The member will not later be eligible if s/he discontinues coverage at some future time.

(E) Retiree Returns to State Employment. A retiree who returns to state employment will become eligible for benefits through MCHCP and will be treated as a new employee. The employee is eligible to enroll in medical, dental, or vision coverage with any coverage level within the first thirty-one (31) days of his/her hire date.

### (3) Enrollment Procedures.

(A) Statewide Employee Benefit Enrollment System (SEBES). A new employee must enroll or waive coverage through SEBES at [www.sebes.mo.gov](http://www.sebes.mo.gov) within thirty-one (31) days of his/her hire date. If enrolling dependents, proof of eligibility must be submitted as defined in section (5).

#### (B) Open Enrollment.

1. An employee may elect coverage and/or change coverage levels during the annual open enrollment period if one (1) of the following occurred:

A. Waived his/her right to insurance when first eligible;

B. Did not enroll eligible dependents when first eligible; or

C. Dropped his/her or dependent coverage during the year.

2. A retiree, terminated vested, long-term disability, or survivor may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If a retiree, terminated vested, long-term disability, or survivor subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in a plan during open enrollment.

#### (C) Special Enrollment Periods.

1. An employee may apply for coverage for himself/herself or for his/her dependents if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of adopted children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. An employee and his/her dependents may enroll within sixty (60) days if s/he involuntarily loses employer-sponsored coverage under one (1) of the following circumstances:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. A retiree, terminated vested, long-term disability, or survivor may apply for dependent coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of adopted children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A retiree, terminated vested, long-term disability, or survivor may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:



(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. MO HealthNet or Medicaid status loss. If an employee who is not retired, terminated, vested, long-term disability, survivor, or his/her dependent loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss.

4. Qualified Medical Child Support Order. If a subscriber receives a court order stating s/he is responsible for coverage of dependent, the subscriber may enroll the dependent in an MCHCP plan within sixty (60) days of the court order.

5. A survivor must submit a survivor enrollment form and a copy of the death certificate within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child or adopts a child, the dependent must be added within thirty-one (31) days of birth, adoption, or marriage.

C. If eligible dependent(s) are not enrolled when first eligible, they cannot be enrolled at a later date.

6. If an active employee has elected coverage as a dependent of another MCHCP subscriber as allowed by these rules, and the subscriber dies before coverage as a dependent goes into effect, the active employee may elect coverage as a subscriber within thirty-one (31) days of the date of death.

(4) Effective Date Provision. In no circumstances can the effective date be before the eligibility date. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

(A) Employee and Dependent Effective Dates.

1. A new employee and his/her dependent's coverage begins on the first day of the month after enrollment through SEBES.

2. Except at initial employment, an employee and his/her eligible dependents' effective date of coverage is the first of the month coinciding with or after the eligibility date. The effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP, except for newborns.

3. The effective date of coverage for a life event shall be as follows:

A. If enrollment by an employee is made before a wedding date, spouse's coverage becomes effective on the wedding date. The monthly premium is not prorated;

B. If enrollment by an employee is made within thirty-one (31) days of a wedding date, spouse's coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form and proof of eligibility;

C. If enrollment by a subscriber is made for a newborn of a member, the effective date for the newborn is the birth date. If enrollment is made by an employee due to the birth of a newborn of the employee, the effective date for the employee and newborn is the first of the month coinciding with or after enrollment is received;

D. If enrollment by an employee is made within thirty-one (31) days after the eligibility date, for an adoption, or placement of adopted children, coverage becomes effective on the eligibility date or the first day of the calendar month coinciding with or after the date the enrollment is received; or

E. If enrollment by an employee is made due to legal guardianship of a dependent within thirty-one (31) days of guardianship effective date, the effective date for the dependent is the first day of the calendar month coinciding with or after the date the enrollment is received.

4. An employee and his/her eligible dependent(s) who elect coverage and/or change coverage levels during open enrollment shall have an effective date of January 1 of the following year.

5. An employee who transferred from a state department with coverage under another medical care plan into a state department covered by this plan, and his/her eligible dependent(s) who were covered by the other medical plan, will have coverage effective immediately if an enrollment form is submitted within thirty-one (31) days of transfer.

6. An employee who terminates all employment with the state (not simply moves from one (1) agency to another) and is rehired as a new state employee before termination of coverage, and his/her eligible dependent(s) who were covered by the plan, will have coverage effective immediately.

A. If the employee's coverage is continuous, s/he cannot increase his/her level of coverage or change plans.

B. If the employee requests coverage within the first thirty-one (31) days of hire date to begin the first of the month after his/her hire date, s/he can make changes to his/her coverage.

C. If an employee cancels coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January.

7. An employee and his/her eligible dependent(s) who transfers from another state agency with MCHCP benefits to an MCHCP state agency will be transferred by the former state agency's human resource or payroll representative through eMCHCP to the new state agency. The employee must inform the former agency of the transfer in lieu of a termination. If the employee's coverage is continuous, s/he cannot increase his/her level of coverage or change plans.

8. A Qualified Medical Child Support Order is effective the first of the month coinciding with or after the form is received by the plan or date specified by the court.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents. Enrollment of a dependent is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, a letter will be sent requesting it. Except for open enrollment, documentation must be received within thirty-one (31) days of the letter date, or eligible dependent(s) will not be added. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage for the applicable dependent will terminate or never take effect. If enrolling dependents during open enrollment, proof of eligibility must be received by November 20, or eligible dependents will not be added for coverage effective the following January 1.

(A) Addition of Dependents. Required documentation should accompany the enrollment for coverage, except when adding a newborn. Failure to provide acceptable documentation with the enrollment will result in the dependent not having coverage until such proof is received, subject to the following:

1. If proof of eligibility is not received with the enrollment, such proof will be requested by letter sent to the subscriber. The enrollment will not be processed until after proof of eligibility is received. Documentation shall be received no later than thirty-one (31) days from the date of the letter requesting such proof. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility. Failure to provide the required documentation in a timely manner will result in the dependent being ineligible for coverage until the next open enrollment period; and

2. Coverage is provided for a newborn of a member from the moment of birth. The member must notify MCHCP of the birth verbally or in writing within thirty-one (31) days of the birth date. The plan will notify the member of the steps to continue coverage. The member is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not continue unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof of eligibility must be submitted within ninety (90) days of the date of birth. If proof of eligibility is not



received, coverage will terminate on day ninety-one (91) from the birth date;

3. Acceptable forms of proof of eligibility are included in the following chart:

<b>Circumstance</b>	<b>Documentation</b>
Birth of dependent(s)	Government-issued birth certificate or other government-issued or legally-certified proof of eligibility listing subscriber as parent and newborn's full name and birth date
Addition of step-child(ren)	Marriage license to biological or legal parent/guardian of child(ren); and government-issued birth certificate or other government-issued or legally-certified proof of eligibility for child(ren) that names the subscriber's spouse as a parent or guardian and child's full name and birth date
Addition of foster child(ren)	Placement papers in subscriber's care
Adoption of dependent(s)	Adoption papers; Placement papers; or Filed petition for adoption; and Lists subscriber as adoptive parent
Legal guardianship of dependent(s)	Court-documented guardianship papers listing member as guardian (Power of Attorney is not acceptable)
Newborn of covered dependent	Government-issued birth certificate or legally-certified proof of eligibility for newborn listing covered dependent as parent with newborn's full name and birth date
Marriage	Marriage license or certificate recognized by Missouri law
Divorce	Final divorce decree; or Notarized letter from spouse stating s/he is agreeable to termination of coverage pending divorce or legal separation
Death	Death certificate
Loss of MO HealthNet or Medicaid	Letter from MO HealthNet or Medicaid stating who is covered and the date coverage terminates
MO HealthNet Premium Assistance	Letter from MO HealthNet or Medicaid stating member is eligible for the premium assistance program
Qualified Medical Child Support Order	Qualified medical child support order
Prior Group Coverage	Letter from previous insurance carrier or former employer stating date coverage terminated, reason for coverage termination, and list of dependents covered

(B) The employee is required to notify MCHCP on the appropriate form of the dependent's name, date of birth, eligibility date, and Social Security number.

(C) Permanently disabled children will continue to be eligible beyond age twenty-six (26) during the continuance of a permanent disability, provided the following documentation is submitted to the plan prior to the dependent's twenty-sixth birthday:

1. The Supplemental Security Income (SSI) Notice of Award from the Social Security Administration (SSA) verifying the dependent is entitled to and receiving disability benefits as of a specific date;

2. A letter from the dependent's physician describing the disability and verifying that the disability predates the SSA determination; and

3. A current benefit verification letter from the SSA confirming the dependent is still considered disabled by SSA.

(D) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. Claims will not be processed until the required information is provided. If Medicare coverage begins before turning age sixty-five (65), the member will receive a Medicare disability questionnaire. The member must submit the completed questionnaire to MCHCP for the Medicare eligibility to be submitted to the medical plan.

(6) Military Leave.

(A) Military Leave for an Employee who is not Retired.

1. For absences of thirty (30) days or less, coverage continues as if the employee has not been absent.

2. For absences of thirty-one (31) days or more, coverage ends unless the employee elects to pay for COBRA coverage. The agency payroll representative must notify MCHCP of the effective date of military leave.

3. If the employee is utilizing annual and/or compensatory balances and receiving a payroll, the dependent coverage is at the active employee monthly premium.

4. If the employee does not elect to continue COBRA coverage for his/her eligible dependent(s), coverage ends effective the last day of the month in which the leave begins.

5. The former employee must submit a form within thirty-one (31) days of the employee's return to work for the same level of coverage with the same plan to be reinstated. The former employee must submit a form and an official document indicating the separation date if s/he elects coverage after thirty-one (31) days of returning to work.

6. Coverage may be reinstated the first of the month in which the member returns to employment, the first of the month after return to employment, or the first of the month after the loss of military coverage.

(B) Military Leave for a Retired Member.

1. A retiree must terminate his/her coverage upon entry into the armed forces of any country by submitting a form and copy of his/her activation papers within thirty-one (31) days of his/her activation date.

2. Coverage will be terminated the last day of the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of his/her separation papers and form within thirty-one (31) days of the separation date.

3. Coverage will be reinstated as of the first of the month in which the employee returns from active duty, the first of the month after the employee returns, or the first of the month after the loss of military coverage.

4. If the retired member fails to reinstate coverage, s/he cannot enroll at a later date.

5. If the employee terminates his/her coverage, dependent coverage is also terminated.

(7) Termination.

(A) Termination of coverage shall occur on the last day of the calendar month coinciding with or after any of the following events, whichever occurs first:

1. Failure to make any required contribution toward the cost of coverage. If MCHCP has not received payment of premium at the end of the thirty-one (31)-day grace period, the subscriber will be retroactively terminated to the date covered by his/her last paid premium. The subscriber will be responsible for the value of services rendered after the retroactive termination date, including, but not limited to, the grace period;

2. Entry into the armed forces of any country as defined in section (6);

3. With respect to employees, termination of coverage shall occur upon termination of employment in a position covered by the MCHCP, except as expressly specified otherwise in this rule. Termination of employee's coverage shall terminate the coverage of dependents, except as specified in subsection (2)(D);

4. With respect to dependents, termination of coverage shall occur upon divorce or legal separation from the subscriber; or when a child reaches age twenty-six (26). A subscriber must terminate coverage for his/her spouse and stepchild(ren) at the time his/her divorce is final.

A. Subscriber shall notify MCHCP when any of subscriber's dependents cease to be a dependent as defined in this chapter. A subscriber cannot cancel coverage on his/her spouse or children during divorce or legal separation proceedings unless s/he submits a notarized letter from his/her spouse stating s/he is agreeable to termination of coverage pending divorce.

B. When a subscriber drops dependent coverage after a divorce, he/she must submit a completed form, a copy of the divorce decree, and current addresses of all affected dependents. Coverage ends on the last day of the month in which the divorce decree and completed form are received by MCHCP or, if requested, the last day of the month in which the divorce was final;

5. Death of dependent. The dependent's coverage ends on the date of death. The subscriber must submit completed form and a copy of the death certificate within thirty-one (31) days of death;

6. Termination due to a member's act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact;

7. Termination due to a member's threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP;

8. A rescission due only to non-payment of a premium, fraud, or intentional misrepresentation. MCHCP shall provide at least thirty (30) days written notice before it rescinds coverage;

9. Termination of coverage shall occur immediately upon discontinuance of the plan, subject to the plan termination provision specified in 22 CSR 10-2.080(1); and

10. If a member receives covered services after the termination of coverage, MCHCP may recover the contracted charges for such covered services from the subscriber or the provider, plus its cost to recover such charges, including attorneys' fees.

(8) Voluntary Cancellation of Coverage.

(A) A subscriber may cancel medical coverage, which will be effective on the last day of the month in which the form is received by MCHCP, unless the subscriber notifies MCHCP on the first calendar day of the month; then cancellation of coverage is effective the last day of the previous month.

1. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, the subscriber may only cancel medical coverage if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

(B) A subscriber may retroactively cancel coverage on his/her spouse to be effective on the last day of the month in which a divorce is final. A copy of the divorce decree must accompany the change request.

(C) If a member receives covered services after the voluntary cancellation of coverage, MCHCP may recover the contracted charges

for such covered services from the subscriber or the provider, plus its cost to recover such charges, including attorneys' fees.

(D) A subscriber may only cancel dental and/or vision coverage during the year for themselves or their dependents for one (1) of the following reasons:

1. Upon retirement; or
2. When beginning a leave of absence.

(9) Continuation of Coverage.

(A) Leave of Absence.

1. An employee on an approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify MCHCP of the leave of absence and any extension of the leave of absence by submitting the required form through eMCHCP. The employee will receive a letter, form, and bill from MCHCP to continue coverage. If the completed form and payment are returned within ten (10) days of receipt, coverage will continue and the employee will be set up on direct bill.

2. If the employee does not elect to continue coverage, coverage for the employee and his/her covered dependents is suspended effective the last day of the month in which the employee is employed.

3. If the employee fails to pay the premium due, coverage on the employee and his/her dependents terminates.

4. If the employee's spouse is a state employee (active or retired), the employee may transfer coverage under the plan in which the spouse is enrolled. If the employee wishes to be covered individually at a later date, s/he can make the change as long as coverage is continuous. When the employee returns to work, s/he and his/her spouse must be covered individually.

5. Any employee on an approved leave of absence who was a member of MCHCP when the approved leave began, but who subsequently terminated coverage in MCHCP while on leave, may recommence his/her coverage in the plan at the same level (employee only or employee and dependents) upon returning to employment directly from the leave. For coverage to be reinstated, the employee must submit a completed form within thirty-one (31) days. Coverage is reinstated on the first of the month coinciding with or after the date the form is received. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and requests reinstatement of coverage.

6. If the employee chooses to maintain employee coverage but not coverage for his/her covered dependents, the employee is eligible to regain dependent coverage upon return to work.

(B) Leave of Absence—Family and Medical Leave Act (FMLA).

1. An employee must be approved for a leave of absence under the FMLA and meet the requirements and guidelines set forth by FMLA and his/her employing agency for his/her employer to continue to pay the monthly contribution toward the employee's and his/her dependents' coverage. Coverage is continuous unless the employee chooses to cancel coverage.

2. If the employee cancels coverage, coverage ends on the last day of the month.

3. If the employee cancels coverage, the employee must submit a completed form within thirty-one (31) days of his/her return to work.

4. If the employee is unable to return to work after his/her FMLA leave ends, s/he may elect leave of absence coverage or suspend his/her coverage. If coverage is suspended at that time, s/he can enroll within thirty-one (31) days of his/her return to work.

(C) Layoff. An employee on layoff status may elect to retain eligibility to participate in the plan by paying the required contribution for a maximum of twenty-four (24) months with recertification of status at least every twelve (12) months by the employing department. The employee will receive a letter, enrollment form, and bill (if applicable) from MCHCP. If the employee chooses to continue coverage, s/he must return the enrollment form to MCHCP within ten (10) days. If the employee fails to pay the premium due, coverage on the

employee and his/her dependents terminates. If the employee's spouse is a state employee (active or retired), the employee may transfer coverage under the plan in which his/her spouse is enrolled. If the employee wishes to be covered individually at a later date, s/he can make the change as long as coverage is continuous. If the employee returns to work with an agency covered by MCHCP, the employee and his/her spouse must be covered individually. Eligibility will terminate if the employee becomes eligible for health benefits as an employee of another employer. If coverage terminates and the employee is recalled to service, eligibility will be as a new employee.

(D) Workers' Compensation.

1. Coverage will automatically be extended to any subscriber who is receiving workers' compensation benefits. Coverage in the plan will be at the same level of coverage (employee only or employee and dependents) and the member must continue to pay the premiums that were previously deducted from his/her paycheck.

2. If the subscriber cancels coverage, coverage will end on the last day of the month in which MCHCP received the cancellation. The employee may enroll in his/her coverage within thirty-one (31) days of returning to work.

3. If the subscriber is no longer eligible for workers' compensation benefits but cannot return to work, the subscriber's status changes to leave of absence.

(E) Reinstatement after Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action, s/he will be allowed to reinstate his/her medical benefit as described below—

1. If the employee is reinstated with back pay, s/he will be responsible for paying any back contributions normally made for his/her coverage;

2. If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making the required contribution for his/her coverage;

3. If the employee does not continue coverage, s/he will be considered a new hire and may enroll in the plan of his/her choice; or

4. If the employee fails to reinstate his/her coverage, s/he cannot enroll in an MCHCP plan until the next open enrollment.

(10) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) Eligibility. In accordance with COBRA, eligible employees and their dependents may temporarily continue their coverage when coverage under the plan would otherwise end. Coverage is identical to the coverage provided under MCHCP to similarly situated employees and family members. If members cancel COBRA coverage, they cannot enroll at a later date.

1. Employees voluntarily or involuntarily terminating employment (for reasons other than gross misconduct) or receiving a reduction in the number of hours of employment may continue coverage for themselves and their covered dependent(s) for eighteen (18) months at their own expense.

2. If a subscriber marries, has a child, or adopts a child while on COBRA coverage, eligible dependents can be added to the subscriber's plan upon notification to MCHCP. The subscriber may also add eligible dependents during open enrollment.

3. Dependents may continue coverage for up to thirty-six (36) months at their own expense if the covered employee becomes eligible to Medicare.

4. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

5. A divorced spouse and dependents may continue coverage at their own expense for up to thirty-six (36) months.

6. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense.

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage, the member may continue coverage for up to twenty-nine (29) months.

8. An employee who is on military leave is eligible for continued coverage for medical and dental care for the lesser of: a) twenty-four (24) months beginning on the date the leave begins; or b) the day after the date the employee fails to apply for or return to their position of employment following leave.

9. If the eligible member has Medicare prior to becoming eligible for COBRA coverage, the member is entitled to coverage under both.

(B) Premium Payments.

1. Initial payment for continuation coverage must be received within forty-five (45) days of election of coverage.

2. After initial premium payment, MCHCP bills on the last working day of the month. There is a thirty-one (31) day grace period for payment of regularly scheduled monthly premiums.

3. Premiums for continued coverage will be one hundred two percent (102%) of the total premium for the applicable coverage level. Once coverage is terminated under the COBRA provision, it cannot be reinstated.

(C) Required Notifications.

1. The subscriber or applicable member must notify MCHCP of a divorce, legal separation, a child turning age twenty-six (26), or Medicare entitlement within sixty (60) days of the event date.

2. The human resource/payroll office of the subscriber must notify MCHCP of an employee's death, termination, or reduction of hours of employment.

(D) Election Periods.

1. When MCHCP is notified that a COBRA-qualifying event has occurred, MCHCP notifies eligible members of the right to choose continuation coverage.

2. Eligible members have sixty (60) days from the date of coverage loss or notification from MCHCP, whichever is later, to inform MCHCP that they want continuation coverage.

3. If eligible members do not choose continuation coverage within sixty (60) days of lost coverage or notification from MCHCP, coverage ends.

(E) Continuation of coverage may be cut short for any of these reasons—

1. The state of Missouri no longer provides group health coverage to any of its employees;

2. Premium for continuation coverage is not paid on time;

3. The covered employee or dependent becomes covered (after the date s/he elects COBRA coverage) under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition s/he may have;

4. The covered employee or dependent becomes entitled to Medicare after the date s/he elects COBRA coverage; or

5. The covered employee or dependent extends coverage for up to twenty-nine (29) months due to disability and there has been a final determination that the individual is no longer disabled.

(11) Missouri State Law COBRA Wrap-Around Provisions.

(A) Missouri law provides that if a member loses group health insurance coverage because of a divorce, legal separation, or the death of a spouse, the member may continue coverage until age sixty-five (65) under two (2) conditions—

1. The member continues and maintains coverage under the thirty-six (36)-month provision of COBRA; and

2. The member is at least fifty-five (55) years old when COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay the entire premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium.

(B) If continuation coverage is not chosen within the proper time frames listed below, continuation of coverage ends—

1. Within sixty (60) days of legal separation or the entry of a

decree of dissolution of marriage or prior to the expiration of a thirty-six (36)-month COBRA period, the legally separated or divorced spouse who seeks such coverage shall give MCHCP written notice of the qualifying event, including his/her mailing address;

2. Within thirty (30) days of the death of an employee whose surviving spouse is eligible for continued coverage or prior to the expiration of a thirty-six (36) month COBRA period, the human resource/payroll representative shall give MCHCP written notice of the death and the mailing address of the surviving spouse; or

3. Within fourteen (14) days of receipt of the notice, MCHCP shall notify the legally separated, divorced, or surviving spouse that coverage may be continued. The notice shall include:

A. A form for election to continue the coverage;

B. The amount of premiums to be charged and the method and place of payment; and

C. Instructions for returning the elections form by mail within sixty (60) days after MCHCP mails the notice.

(C) Continuation of coverage terminates on the last day of the month prior to the month the subscriber turns age sixty-five (65). The right to continuation coverage shall also terminate upon the earliest of any of the following:

1. The state of Missouri no longer provides group health coverage to any of its employees;

2. Premium for continuation coverage is not paid on time;

3. The date on which the legally separated, divorced, or surviving spouse becomes insured under any other group health plan;

4. The date on which the legally separated, divorced, or surviving spouse remarries and becomes insured under another group health plan; or

5. The date on which the legally separated, divorced, or surviving spouse reaches age sixty-five (65).

(12) Medicare.

(A) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(B) MCHCP's prescription drug plan is evaluated by a third party to determine whether it is creditable and considered equal to or better than Medicare Part D. The member will receive notification of the outcome from MCHCP. If MCHCP's plan is considered creditable, the member does not need to enroll in Medicare Part D and will not be penalized if s/he signs up for Part D at a later date.

(C) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the donut hole.

(13) Communications to Members.

(A) It is the member's responsibility to ensure that MCHCP has current contact information for the member and any dependent(s).

(B) A member must notify MCHCP of a change in his/her mailing or email address as soon as possible, but no later than thirty-one (31) days after the change.

(C) It is the responsibility of all members who elect to receive plan communication through email to ensure plan emails are not blocked as spam or junk mail by the member or by the member's service provider.

(D) Failure to update a mailing or email address may result in

undeliverable mail/email of important informational material, delayed or denied claims, loss of coverage, loss of continuation rights, missed opportunities relating to covered benefits, and/or liability for claims paid in error.

(14) Deadlines. Unless specifically stated otherwise, MCHCP computes deadlines by counting day one as the first day after the qualifying event. If the last day falls on a weekend or state holiday, MCHCP may receive required information on the first working day after the weekend or state holiday.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency rescission and rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rescission and rule covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-2.030 Contributions.** The Missouri Consolidated Health Care Plan is amending sections (1) and (2); adding sections (3)–(5); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the contributions made to the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) Total premium costs for various *[classes]* levels of employee *[participation]* coverage are based on employment status, eligibility for Medicare, and *[for]* various classifications of dependent participation *[are]* as established by the plan administrator.

(2) The employee's contribution *[by the employee]* toward total premium shall be determined by the plan administrator *[for state employees]*.

(3) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree premium is based on creditable years of service at retirement with the state. It is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by Missouri State Employees' Retirement System (MOSERS) or Public School Retirement System (PSRS) multiplied by two and one half percent (2.5%). The resulting product shall be capped at sixty-five percent (65%). After the percentage is computed, the percentage is multiplied by the PPO 600 Plan total premium for non-Medicare retirees, the percentage is multiplied by the PPO 600 Plan total premium reduced by both the tobacco-free incentive and the wellness incentive. The resulting product is the MCHCP contribution, which shall be subtracted from the total premium of the plan chosen by the retiree. The difference is the amount of the retiree contribution toward the total premium.

(4) Premium. Payroll deductions, Automated Clearing House (ACH) transactions, and/or direct bills are processed by MCHCP.

(A) Active Employee Whose Payroll Information is Housed in the SAM II Human Resource System.

1. Monthly medical premium payroll deductions are divided in half and taken by MCHCP at the end of the prior month and the fifteenth of the current month for the current month's coverage (example: September 30 and October 15 payroll deductions are taken for October medical premiums).

2. Monthly dental and vision premium payroll deductions are divided in half and taken by MCHCP on the fifteenth of the current month and the end of the current month for the current month's dental and vision coverage (example: October 15 and October 31 payroll deductions are taken for October dental and vision premiums).

A. If past premiums are owed due to timing of the receipt of the form, timing of the receipt of proof of eligibility or other circumstances, premium payroll deductions due are divided and taken in up to three (3) of the employees' future payrolls and/or additional payrolls at the discretion of MCHCP.

(B) Active Employee Whose Payroll Information is Not Housed in the SAM II Human Resource System.

1. Premium payroll deductions are submitted to MCHCP monthly from the agency based on the deductions taken from the employee's payroll.

A. Medical premium payroll deduction received at the end of the month is applied to the employee's next month's coverage (example: September 30 payroll deduction is taken for the October medical premium).

B. Dental and vision premium payroll deductions received at the end of the month are applied to the current month's dental and vision coverage (example: September 30 payroll deductions are taken for September dental and vision premiums).

C. If premiums are owed due to timing of the receipt of the change, the agency collects the premiums owed and includes the premium with the monthly deductions submitted the next month.

(C) Retirees and Survivors Premiums From Benefit Check.

1. Deduction amounts are received monthly from MOSERS based on the deductions taken from the benefit checks. Medical, dental, and vision deductions received at the end of the month pay for the next month's coverage (example: September 30 benefit

check deduction is taken for October medical, dental, and vision premiums).

(D) Direct Bill for Consolidated Omnibus Budget Reconciliation Act (COBRA), Long-term Disability, Leave of Absence, Terminated Vested, Retiree, and Survivor Members.

1. Medical, dental, and vision premiums are billed on the last working day of the month for the next month's coverage. Premiums are due fifteen (15) days from the last day of the month in which they are billed (example: bill mailed September 30 for October medical, dental, and vision premiums, premium due October 15).

2. If a member is in arrears for two (2) months of premiums and payment is not received by the fifteenth of the second month for which premiums are due, coverage is terminated due to nonpayment on the last day of the month for which full premium was received. The member will be responsible for the value of the services rendered after the retroactive termination date (example: bill sent September 30 for October premiums and no payment received; bill mailed October 31 for October and November premiums due on November 15. If payment is not received, coverage will be terminated due to nonpayment effective September 30).

(E) ACH Electronic Payment of Premiums for COBRA, Long-term Disability, Terminated Vested, Retiree, and Survivor Members.

1. Medical, dental, and vision premiums are deducted from a subscriber's bank account on the fifth of the month to pay for the current month's coverage (example: October 5 deduction taken for October medical, dental, and vision premiums).

2. If there are insufficient funds, MCHCP will send the member a letter and bill requesting payment. If a payment is in arrears, the direct bill timeline applies as defined in paragraph (4)(D)2.

#### (5) Premium Payments.

(A) By enrolling in coverage under MCHCP, a member agrees that MCHCP may deduct the member's contribution toward the total premium from the member's paycheck. Payment for the first month's premium is made by payroll deduction. Double deductions may be taken to pay for the first month's coverage depending upon the date the enrollment is received and the effective date of coverage. Subsequent premium payments are deducted from the member's payroll.

(B) A retiree or survivor has a choice to have the premium deducted from his/her retirement check or survivor's benefit check, automatically withdrawn from the retiree's or survivor's bank account, or may receive a monthly bill from MCHCP.

1. If the retirement check or survivor's benefit check is not sufficient to cover the premium, the retiree's or survivor's contribution toward total premium, the contribution may be either automatically withdrawn from the retiree's or survivor's bank account, or the retiree or survivor may elect to receive a monthly bill.

2. If the retiree or survivor fails to make the necessary premium payments, coverage terminates on the last day of the month for which full premium payment was received.

3. If coverage terminates on the retiree, survivor, vested, or COBRA subscriber or his/her dependents, the subscriber cannot enroll in the plan at a later date. The subscriber is responsible for claims submitted after the termination date.

(C) If a member fails to pay premiums on the required due date, MCHCP allows a thirty-one (31)-day grace period. In the event that MCHCP has not received payment of premium at the end of the thirty-one (31)-day grace period, the member will be retroactively terminated to the date covered by the member's last paid premium. The member will be responsible for the value of the services rendered after the retroactive termination date, including, but not limited to, the grace period.

[(3)](6) Refunds of overpayments are limited to the amount overpaid during the twelve (12)-month period ending at the end of the month preceding the month during which notice of overpayment is received.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

### EMERGENCY AMENDMENT

**22 CSR 10-2.045 Plan Utilization Review Policy.** The Missouri Consolidated Health Care Plan is amending section (1).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan Medical Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Prior [a]Authorization of [s]Services—The claims administrator must authorize some services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. [Participants] Members who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent

omission about the person's health condition or the cause of the condition will not be covered.

1. The following medical services are subject to prior authorization:

A. Ambulance services for non-emergent use whether air or ground;

**B. Anesthesia and hospital charges for dental care for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;**

*[B./C. Applied behavior analysis for autism;*

**D. Auditory brainstem implant (ABI);**

**E. Bariatric procedures;**

*[C./F. Cardiac and pulmonary rehabilitation after thirty-six (36) visits within a twelve (12)-week period;*

*[D./G. Chiropractic services after twenty-six (26) visits annually;*

*[E./H. Cochlear implant device;*

**I. Chelation therapy;**

*[F./J. Dental care to reduce trauma and restorative services when the result of accidental injury;*

*[G./K. Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;*

*[H./L. Genetic testing or counseling;*

*[I./M. Home health care and palliative services;*

*[J./N. Hospice care;*

*[K./O. Hospital inpatient services except for observation stays;*

*[L./P. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;*

*[M./Q. Nutritional counseling after three (3) sessions annually;*

*[N./R. Orthotics over one thousand dollars (\$1,000);*

*[O. Oxygen provided on an outpatient basis;]*

*[P./S. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;*

**T. Procedures with codes ending in "T";**

*[Q./U. Prostheses over one thousand dollars (\$1,000);*

*[R./V. Skilled nursing facility;*

*[S./W. Surgery (outpatient)—The following outpatient surgical procedures: **cornea transplant**, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, **stimulators for bone growth**, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); *[surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth; reduction of fractures and dislocations of the jaw; excision of exostosis of jaws and hard palate; external incisions and drainage of cellulitis; incision of accessory sinuses, salivary glands, or ducts; or frenectomy];* and*

*[T./X. Transplants including requests related to covered travel and lodging.*

2. The following pharmacy services are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications. *[Drugs that treat chronic, complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis. The specialty medication requires frequent dosage adjustments, clinical monitoring, and special*

*handling and are often unavailable at retail pharmacies. The specialty medication must be filled through the claims administrator's home delivery pharmacy provider];*

C. Medications that may be prescribed for several conditions, including some *[where] for which* treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. The cost of the medication exceeds nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents (\$1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications.

3. Prior authorization time frames.

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen (15)-calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least forty-five (45) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

(B) Concurrent Review—The claims administrator will monitor the medical necessity of the inpatient admission to certify the necessity of the continued stay in the hospital. *[Participants] Members* who have another primary carrier, including Medicare, are not subject to this provision; and

(C) Retrospective Review—Reviews conducted after services have been provided to a patient. The retrospective review **does not** include/s/ the review of a claim that is limited to an evaluation of reimbursement levels, accuracy, and adequacy of documentation or coding, or settling of payment.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

### EMERGENCY AMENDMENT

**22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1)–(3); adding sections (4)–(7); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the PPO 300 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.*

**EMERGENCY STATEMENT:** *This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) Deductible amount—Network: per individual each calendar year, three hundred dollars (\$300); family *[limit]* each calendar year, six hundred dollars (\$600). Non-network: per individual each calendar year, six hundred dollars (\$600); family *[limit]* each calendar year, one thousand two hundred dollars (\$1,200).

*[(C)] Married, active employees who are Missouri Consolidated Health Care Plan (MCHCP) subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all medical information of the family unit. Failure to report an active employee spouse when newly hired and during open enrollment will result in a separate deductible and coinsurance for both active employees.]*

*[(D)](C) During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and coinsurance. [The newborn will not be subject to a separate deductible and coinsurance.] The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital. If the mother is not a Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.*

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims/—/ are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims/—/ are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(D) Claims shall be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within one hundred (100) miles of his/her home. The *[participant] member* must contact the claims administrator before the

date of service in order to have a local provider approved. Such approval is for three (3) months. After three (3) months, the *[participant] member* must contact the claims administrator to reassess network availability.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) The family out-of-pocket maximum is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member out-of-pocket maximums may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

*[(A)](C) Network out-of-pocket maximum for individual—one thousand two hundred dollars (\$1,200).*

*[(B)](D) Network out-of-pocket maximum for family—two thousand four hundred dollars (\$2,400).*

*[(C)](E) Non-network out-of-pocket maximum for individual—two thousand four hundred dollars (\$2,400).*

*[(D)](F) Non-network out-of-pocket maximum for family—four thousand eight hundred dollars (\$4,800).*

*[(E)](G) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: claims for services paid at one hundred percent (100%); charges above the *[U]*usual, *[C]*customary, and *[R]*reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.*

(4) Married, active employees who are MCHCP subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all claim and payment information of the family unit. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(5) Expenses toward the deductible and out-of-pocket maximum will not be transferred if the member changes medical plans during the plan year. When the member is enrolled in a Coventry Health Care Plan and moves to a different region, expenses toward the deductible and out-of-pocket maximum will be transferred if the member chooses an equivalent UMR plan.

(6) Copayments—set charges for the following services apply as long as network providers are utilized. Copayments do not apply to the deductible or out-of-pocket maximum.

(A) Office visit—primary care: twenty-five dollars (\$25); specialist: forty dollars (\$40); chiropractor and/or manipulation: twenty dollars (\$20); urgent care: fifty dollars (\$50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the deductible and coinsurance.

1. Vision office visit or refraction: forty dollars (\$40);

2. Hearing test—performed by a primary care provider: twenty-five dollars (\$25); performed by a specialist: forty dollars (\$40).

(B) Emergency room—two hundred dollars (\$200) network and non-network. Emergency room copayment includes all facility and ancillary medical services received during the emergency room visit. If a member is admitted to the hospital, the copayment is waived and all services apply to the deductible and coinsurance.



**(7) Usual, customary, and reasonable fee allowed—non-network medical claims are allowed at the eighty-fifth percentile of usual, customary, and reasonable fees as determined by the vendor.**

*[(4)](8)* Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

## **Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN**

### **Division 10—Health Care Plan Chapter 2—State Membership**

#### **EMERGENCY AMENDMENT**

**22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1)–(3); adding sections (4)–(6); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) Deductible amount—Network: per individual each calendar year, six hundred dollars (\$600); family *[limit]* each calendar year, one

thousand two hundred dollars (\$1,200). Non-network: per individual each calendar year, one thousand two hundred dollars (\$1,200); family *[limit]* each calendar year, two thousand four hundred dollars (\$2,400).

*[(C)](C)* Married, active employees who are Missouri Consolidated Health Care Plan (MCHCP) subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all medical information of the family unit. Failure to report an active employee spouse when newly hired and during open enrollment will result in a separate deductible and coinsurance for both active employees. ]

*[(D)](C)* During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and coinsurance. *[The newborn will not be subject to a separate deductible and coinsurance.]* The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if he/she is transferred to another hospital. **If the mother is not a Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.**

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims/—/ are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims/—/ are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(D) Claims shall be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within one hundred (100) miles of his/her home. The *[participant]* member must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is for three (3) months. After three (3) months, the *[participant]* member must contact the claims administrator to reassess network availability.

(3) Out-of-pocket maximum—the maximum amount payable by the *[participant]* member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) The family out-of-pocket maximum is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member out-of-pocket maximums may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

*[(A)](C)* Network out-of-pocket maximum for individual—one thousand five hundred dollars (\$1,500).

*[(B)](D)* Network out-of-pocket maximum for family—three thousand dollars (\$3,000).

*[(C)](E)* Non-network out-of-pocket maximum for individual—three thousand dollars (\$3,000).

*[(D)](F)* Non-network out-of-pocket maximum for family—six thousand dollars (\$6,000).

*[(E)](G)* Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: claims for services paid at one hundred percent (100%); charges above the *[U]*usual, *[C]*customary, and *[R]*reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a

non-network provider.

(4) Married, active employees who are MCHCP subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all claim and payment information of the family unit. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(5) Expenses toward the deductible and out-of-pocket maximum will not be transferred if the member changes medical plans during the plan year. When the member is enrolled in a Coventry Health Care Plan and moves to a different region, expenses toward the deductible and out-of-pocket maximum will be transferred if the member chooses an equivalent UMR plan.

(6) Usual, customary, and reasonable limit fee allowed—non-network medical claims are processed at the eighty-fifth percentile of usual, customary, and reasonable fees as determined by the vendor.

[(4)](7) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership  
EMERGENCY AMENDMENT**

**22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is deleting section (5); amending sections (1)–(3) and (6); adding sections (4), (8), and (9); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the High Deductible Health Plan benefit provisions and covered charges of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unex-*

*pected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) Deductible amount—Network: per individual each calendar year, one thousand two hundred dollars (\$1,200); family *[limit]* each calendar year, two thousand four hundred dollars (\$2,400). Non-network: per individual each calendar year, two thousand four hundred dollars (\$2,400); family *[limit]* each calendar year, four thousand eight hundred dollars (\$4,800).

(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.

[(A)](B) The family deductible *[must be met before claim payments begin, applicable when two (2) or more family members are covered]* applies when two (2) or more family members are covered. The family deductible must be met before claim payment begins for any covered member.

[(B)] If both a husband and wife are state employees covered by Missouri Consolidated Health Care Plan (MCHCP) and they both enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), they must each have a separate HSA. The maximum contribution MCHCP will make for the family is one thousand four hundred dollars (\$1,400) regardless of the number of HSAs or the number of children covered under the HDHP for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a seven-hundred-dollar (\$700) contribution to each spouse, to total one thousand four hundred dollars (\$1,400).

(C) Married, active employees who are MCHCP subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all medical information of the family unit. Failure to report an active employee spouse when newly hired and during open enrollment will result in a separate deductible and coinsurance for both active employees.]

[(D)](C) During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and *[coinsurance]* out-of-pocket maximum. *[The newborn will not be subject to a separate deductible and coinsurance.]* The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital. **If the mother is not a Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.**

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of

the calendar year once the out-of-pocket maximum is reached.

(A) Network claims/—/ are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims/—/ are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(D) Claims shall be paid at eighty percent (80%) if the subscriber requires covered services that are not available through network provider within one hundred (100) miles of his/her home. The *[participant]* member must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is for three (3) months. After three (3) months, the *[participant]* member must contact the claims administrator to reassess network availability.

(3) Out-of-pocket maximum—the maximum amount payable by the *[participant]* member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before claim payment begins for any covered member.

*[(A)](C)* Network out-of-pocket maximum for individual—two thousand four hundred dollars (\$2,400).

*[(B)](D)* Network out-of-pocket maximum for family—four thousand eight hundred dollars (\$4,800).

*[(C)](E)* Non-network out-of-pocket maximum for individual—four thousand eight hundred dollars (\$4,800).

*[(D)](F)* Non-network out-of-pocket maximum for family—nine thousand six hundred dollars (\$9,600).

*[(E)](G)* Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: claims for services paid at one hundred percent (100%); charges above the *[U]*usual, *[C]*customary, and *[R]*reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(4) Married, active employees who are MCHCP subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all claim and payment information of the family unit. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

*[(4)](5)* Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

*[(5) Pharmacy benefits are subject to the HDHP deductible and coinsurance.]*

(6) A member does not qualify for the HDHP if *[they are]* s/he is covered under or enrolled in any of the following types of insurance plans or programs:

(E) The *[participant]* member has veteran's benefits that have been used within the past three (3) months.

(8) Health Savings Account (HSA) Contributions.

(A) To receive contributions from MCHCP, the employee must open a HSA with the bank designated by MCHCP.

(B) MCHCP will make a twenty-five dollar (\$25) monthly contribution to the employee's HSA account to total three hundred dollars (\$300) annually. If a family is enrolled, MCHCP will make a fifty dollar (\$50) contribution to the employee's HSA account to total six hundred dollars (\$600) annually.

(C) If both a husband and wife are state employees covered by MCHCP and they both enroll in a HDHP with HSA, they must each have a separate HSA. The maximum contribution MCHCP will make for the family is six hundred dollars (\$600) regardless of the number of HSAs or the number of children covered under the HDHP for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a three hundred dollar (\$300) contribution to each spouse to total six hundred dollars (\$600).

(9) Usual, customary, and reasonable fee allowed—non-network medical claims are processed at the eighty-fifth percentile of usual, customary, and reasonable fees as determined by the vendor.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

### EMERGENCY RESCISSION

**22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges.** This rule established the policy of the board of trustees in regard to the Medical Plan Benefit Provisions and covered charges for participation in the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded and readopted to include detailed language to clarify medical plan benefit provisions and covered charges.*

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rescission is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rescission reflects changes made to the plan by the*

*Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the Missouri Register. This emergency rescission complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

**AUTHORITY:** section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY RULE**

**22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges**

**PURPOSE:** *This rule establishes the policy of the board of trustees in regard to the Medical Plan Benefit Provisions and Covered Charges for participation in the Missouri Consolidated Health Care Plan.*

**PUBLISHER'S NOTE:** *The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.*

**EMERGENCY STATEMENT:** *This emergency rule must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the Missouri Register. This emergency rule complies with the protections extended by the Missouri and United States Constitutions and limits its*

*scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) Benefit Provisions Applicable to the PPO 300 Plan, PPO 600 Plan, and High Deductible Health Plan (HDHP). Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(2) Covered Charges Applicable to the PPO 300 Plan, PPO 600 Plan, and HDHP.

(A) Covered charges are only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a non-covered service. This includes covered services:

1. Prescribed by an appropriate health care provider for the therapeutic treatment of injury or sickness;

2. To the extent they do not exceed any limitation or exclusion; and

3. For not more than the usual, customary, and reasonable charge, as determined by the claims administrator for the services provided, will be considered covered charges.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, reasonable, and customary, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and

2. The usual, customary, and reasonable charges in the area in which services and/or supplies are provided.

(C) A physician visit to seek a second opinion is a covered service.

(D) Services in a Country Outside of the United States. Emergency room and urgent care medical services are covered at the network benefit. All other non-emergency services are covered at the non-network benefit.

(E) Medical plan benefits, limitations, and exclusions effective January 1, 2012, are incorporated by reference into this rule and are available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, or online at [www.mchcp.org](http://www.mchcp.org). This rule does not include any later amendments or additions.

(F) Plan benefits for the PPO 300 Plan, PPO 600 Plan, and HDHP are as follows:

1. Allergy testing and immunotherapy. Allergy testing and allergy immunotherapy is covered for members with clinically significant allergic symptoms. No coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning;

2. Ambulance service. Ambulance transport services involve the use of specially designed and equipped vehicles to transport ill or injured individuals. Ambulance transportation by ground to the nearest appropriate facility is covered when medically necessary and other means of transportation would be contraindicated. This can include emergent and non-emergent, yet medically necessary situations. Ambulance transportation by air to the nearest appropriate facility is covered when medically necessary and only if the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Use of air ambulance or medical helicopter service from any country returning to the U.S. is excluded;

3. Applied behavior analysis for autism. For children younger than age nineteen (19), the design, implementation, and evaluation of

environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior are covered with a forty thousand dollar (\$40,000) annual limit. The annual limit may be exceeded, upon prior authorization by the medical plan, if services beyond the annual limit are medically necessary;

4. Bariatric surgery. Open or laparoscopic Roux-en-Y gastric bypass (RYGB), open or laparoscopic sleeve gastrectomy (SG), open or laparoscopic biliopancreatic diversion (BPD) with or without duodenal switch (DS), or laparoscopic adjustable silicone gastric banding (LASGB) are covered when specific health criteria are met;

5. Birth control devices and injections. Birth control is any method used to prevent pregnancy. Food and Drug Administration (FDA)-approved birth control devices and injections are covered when administered in a physician's office;

6. Cancer trials. Coverage for routine patient care costs incurred as the result of a Phase II, III, or IV clinical trial that is approved by an appropriate entity and is undertaken for the purposes of the prevention, early detection, or treatment of cancer. Coverage includes routine patient care costs incurred for drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's condition. Coverage includes reasonable and medically-necessary services needed to administer the drug or use the device under evaluation in the clinical trial;

7. Cardiac rehabilitation. Coverage for an electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) as medically necessary when it is individually prescribed by a physician and a formal exercise stress test is completed following the event and prior to the initiation of the program. Up to thirty-six (36) visits are covered within a twelve (12)-week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

8. Chelation therapy. Chelation therapy agents covered for FDA-approved indication(s) and associated condition(s). Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit are explicitly excluded under MCHCP's benefit plan. Therefore, treatment of metal toxicity that occurs as a result of occupational exposure is not covered;

9. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered. Up to twenty-six (26) visits covered annually. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

10. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation is covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device.

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

11. Dental care/accidental injury. Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors, or cysts. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5), the severely disabled, or a person with a medical or behavioral con-

dition that requires hospitalization. General anesthesia is covered when dental care is provided in a participating or non-participating hospital or surgical center;

12. Durable medical equipment (DME)/medically necessary disposable supplies. DME is covered when the equipment is ordered by a physician to treat an injury or sickness (illness). DME includes, but is not limited to, insulin pumps, oxygen, augmentative communication devices, and manual and powered mobility devices. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, colostomy and ureterostomy bags and prescription compression stockings, are covered. Prescription compression stockings are limited to two (2) pairs or four (4) individual stockings per plan year. Non-reusable disposable supplies, including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered. Repair and replacement of DME is covered when—

A. Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

B. Routine wear and tear of the equipment renders it non-functional and the member still requires the equipment; or

C. The physician provides documentation that the condition of the member changes or if growth-related;

13. Emergency room services. An emergency medical condition is defined as the manifestation of acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If admitted to hospital, may be required to transfer to network facility for maximum benefit;

14. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

15. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when associated with systemic conditions that are significant enough to result in severe circulatory insufficiency and/or areas of desensitization in the lower extremities and service is provided by a qualified health provider. Foot care is considered routine in nature and not medically necessary in the absence of systemic disease that has resulted in severe circulatory insufficiency and/or areas of desensitization in the lower extremities;

16. Genetic counseling. The National Society of Genetic Counselors defines genetic counseling as: "The process of helping people understand and adapt to the medical, psychological and familial implications of genetic contributions to disease." Pre-test and post-test genetic counseling with a physician or a licensed or certified genetic counselor covered as medically necessary for an individual recommended for covered heritable genetic testing;

17. Genetic testing. No coverage for testing based on family history alone. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

A. The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

B. The result of the test will directly impact the treatment being delivered to the member;

C. The testing method is considered scientifically valid for identification of a genetically linked heritable disease; and

D. After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

18. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

19. Hair prostheses. Prostheses and expenses for scalp hair

protheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars (\$200), and the lifetime maximum is three thousand two hundred dollars (\$3,200);

20. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars (\$1,000).

B. Programmable: two thousand dollars (\$2,000).

C. Digital: two thousand five hundred dollars (\$2,500).

D. Bone Anchored Hearing Aid (BAHA): three thousand five hundred dollars (\$3,500);

21. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by physician;

22. Home health care. Skilled home health care is covered for members who are homebound because of illness or injury (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent, or of short duration, or to receive medical care); services must be performed by a registered nurse or licensed practical (vocational) nurse, licensed therapist, or a registered dietitian;

23. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care which is directed mostly toward palliative care and symptom management) and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week;

24. Hospital (includes inpatient, outpatient and surgical centers). The following benefits are covered:

A. Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

B. Intensive care unit room and board;

C. Surgery, therapies, and ancillary services—

(I) Cornea transplant-travel and lodging are not covered for cornea transplant;

(II) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(III) Sterilization for the purpose of birth control is covered;

(IV) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(V) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19); and

(VI) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

D. Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(I) Member must be ill in more than one area of daily living to such an extent that s/he is rendered dysfunctional and requires

the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(II) The member's mental health disorder must be treatable in an inpatient facility;

(III) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual* (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region; and

(IV) The attending physician must be a psychiatrist. If the admitting physician is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board eligible or board certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of mental health disorders;

E. Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multi-disciplinary services not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and pre-occupational modalities. Such programs must be a less-restrictive alternative to inpatient treatment;

F. Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and

G. Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one of the following:

(I) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(II) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(III) A state-licensed psychologist;

(IV) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(V) Licensed professional counselor;

25. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition;

26. Maternity coverage. Prenatal and postnatal care is covered. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two (2)-visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility;

27. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program when ordered by a physician or physician extender

and provided by a licensed health-care professional (e.g., a registered dietitian), up to three (3) sessions annually with a registered dietitian with physician order. The maximum may be exceeded for an additional three (3) sessions, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program because they are not considered to be medically necessary. Conditions for which nutritional evaluation and counseling are not considered to be medically necessary include, but are not limited to, the following:

- A. Attention-deficit/hyperactivity disorder (ADHD);
- B. Chronic fatigue syndrome (CFS);
- C. Idiopathic environmental intolerance (IEI); or
- D. Asthma;

28. Nutritional therapy. Nutritional therapy is covered when it is the sole source of nutrition or a significant percentage of the daily caloric intake; is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder; is prescribed by a physician; is necessary to sustain life or health; and requires ongoing evaluation and management by a licensed healthcare provider;

29. Office visit. Member encounter with a health care or mental health care/chemical dependency provider in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan being provided, including non-specialty infusions and injections. Specialty injections NEUPOGEN® (Filgrastim) and Neulasta® (Pegfilgrastim) are covered under the medical plan when the treating physician deems it medically necessary to be administered in the physician's office rather than as a self-injectable;

30. Orthotics. Therapeutic shoes, inserts, and/or modifications to therapeutic shoes; thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis; helmets-covered when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living; and cranial orthosis for plagiocephaly, cervical orthosis, hip orthosis, knee orthosis, and ankle-foot/knee-ankle-foot orthoses (AFO) are covered;

31. Physical, speech, and occupational therapy and rehabilitation services (outpatient). Up to sixty (60) combined visits allowed per incident if showing significant improvement. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

32. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Annual physical exams (well man, woman, and child) and routine lab and X-ray services ordered as part of the annual exam. One exam (1) per calendar year is covered. For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

F. Cancer screenings:

- (I) Mammograms—one exam per year, no age limit;
- (II) Pap smears—one per year, no age limit;
- (III) Prostate—one per year, no age limit; and
- (IV) Colorectal Screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive regardless of diagnosis. Virtual colonoscopy

covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Flu vaccination (influenza). The seasonal flu vaccine is covered under the preventive care benefit. When shot is obtained out-of-network, member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive up to twenty-five dollars (\$25). Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.

(I) Standard or preservative-free injectable influenza vaccine is a medically necessary preventive service for members when influenza immunization is recommended by the member's doctor.

(II) Intradermal influenza vaccine is a medically necessary preventive service for members eighteen (18) to sixty-four (64) years of age when influenza immunization is recommended by the member's doctor.

(III) Intranasally administered influenza vaccine is a medically necessary alternative to injectable influenza vaccine for immunocompetent healthy persons two (2) to forty-nine (49) years of age when influenza immunization is recommended by the member's doctor;

33. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition or if growth-related;

34. Pulmonary rehabilitation. Up to thirty-six (36) visits within a twelve (12)-week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and postoperative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) and/or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake ( $\text{VO}_2\text{max}$ ) equal to or less than twenty milliliter per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METs); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

35. Skilled nursing facility. Benefits are limited to one hundred twenty (120) days per calendar year;

36. Stimulators (for bone growth). Implantable bone growth stimulators covered as an outpatient surgery, nonimplantable bone growth stimulator covered under durable medical equipment.

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic



Accelerated Fracture Healing System (SAFHS)). Medically-necessary DME to accelerate healing of fresh fractures, fusions, or delayed unions.

B. Electrical stimulation: direct current electrical bone-growth stimulator medically necessary for delayed unions of fractures or failed arthrodesis, non-unions, failed fusions, and congenital pseudarthrosis and members who are at high risk for spinal fusion failure;

37. Transplants. When neither experimental nor investigational and medically necessary: bone marrow, kidney, liver, heart, lung, pancreas, intestinal, or any combination are covered under the transplant benefits. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements. Travel, if approved, is limited to ten thousand dollars (\$10,000) maximum per transplant.

A. Network. Includes travel and lodging allowance for recipient and his/her immediate family travel companion (younger than nineteen (19), both parents) if transplant facility is more than one hundred (100) miles from residence.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to [www.gsa.gov](http://www.gsa.gov) for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Transplant benefits at a non-network facility. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals not covered. Non-network facility charges and payments for transplants are limited to the following maximum only:

(I) Allogenic bone marrow—one hundred forty three thousand dollars (\$143,000);

(II) Autologous bone marrow—one hundred twenty-one thousand dollars (\$121,000);

(III) Heart—one hundred twenty-eight thousand dollars (\$128,000);

(IV) Heart and lung—one hundred thirty-three thousand dollars (\$133,000);

(V) Lung—one hundred fifty-one thousand dollars (\$151,000);

(VI) Kidney—Fifty-four thousand dollars (\$54,000);

(VII) Kidney and Pancreas—ninety-seven thousand dollars (\$97,000); and

(VIII) Liver—one hundred fifty-three thousand dollars (\$153,000).

38. Urgent care. Services to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician's office but not severe enough to require treatment in a hospital emergency department; and

39. Vision. Routine exam (including refractions). One (1) per covered person per calendar year.

**AUTHORITY:** section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the *Code of State Regulations*. Emergency rescission and rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rescission and rule covering this same material is published in this issue of the *Missouri Register*.

## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN

### Division 10—Health Care Plan Chapter 2—State Membership

#### EMERGENCY AMENDMENT

**22 CSR 10-2.075 Review and Appeals Procedure.** The Missouri Consolidated Health Care Plan is amending sections (1)–(5); adding section (1); and renumbering as necessary.

**PURPOSE:** *This amendment changes the policy of the board of trustees in regard to review and appeals procedures for participation in, and coverage of services under, the Missouri Consolidated Health Care Plan.*

**EMERGENCY STATEMENT:** *This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

**(1) General Provision. The board of trustees has the right to suspend, revise, or remove eligibility and benefit requirements in the case of a disaster or emergency situation.**

**[(1)](2) Claims Submissions and Initial Benefit Determinations.**

(A) Members shall use the claims and administration procedures established by the vendor administering the particular service for which coverage, authorization, or payment is sought.

(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.

1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a decision whether a treatment, procedure, or medication is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days from the date the vendor receives the claim. The vendor may extend the time period up to an additional fifteen (15) days if, for reasons beyond the vendor's control, the decision cannot be made within the first fifteen (15) days. The vendor must



notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor as soon as possible thereafter.

2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than thirty (30) days after the vendor receives the claim. If, because of reasons beyond the vendor's control, more time is needed to review the claim, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

3. Concurrent claims are claims related to an ongoing course of previously[-] approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously[-] approved course of treatment in sufficient time to allow the member or the member's provider to appeal and obtain a determination before the benefit is reduced or terminated.

(C) Claims incurred should be furnished to the vendor by the provider or the member as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the vendor before they are paid.

(D) If a member, or a provider or authorized representative on behalf of a member, submits a request for coverage or a claim for services that is denied in whole or in part, the member will receive an initial denial notice within the time frames described in this rule that will include the following information:

1. The reasons for the denial;
2. Reference to the plan provision, regulation, statute, clinical criteria, or guideline on which the denial was based, with information as to how the member can obtain a copy of the provision, regulation, statute, clinical criteria, or guideline free of charge;
3. A description of any documentation or information that is necessary for the member to provide if documentation or information is missing and an explanation as to why the documentation or information is needed, if applicable; and
4. Information as to steps the member can take to submit an appeal of the denial.

#### //2//3 General Appeal Provisions.

(A) All individuals seeking review or appeal of a decision of the plan, plan administrator, claims administrator, or any vendor shall follow the procedures applicable to the type of decision appealed as set forth in this rule.

(B) All appeals must be submitted in writing to the appropriate reviewer as established in this rule by the member, the individual

seeking review, or his/her authorized representative.

(C) Unless specifically provided otherwise in this rule, all appeals to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of receiving the denial or notice which gave *[rights]* rise to the appeal.

#### //3//4 Appeal Process for Medical and Pharmacy Determinations.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply.

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage *[once]* after an individual has been covered under the plan.

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination.

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative.

4. External review. External review means a review of an adverse benefit determination (including a final internal adverse benefit determination) by the Missouri Department of Insurance, Financial Institutions and Professional Registration, Division of Consumer Affairs (DIFP) regarding covered medical *[and pharmacy]* benefits administered by *[plan vendors, UMR, Mercy Health Plans, or Express Scripts Inc.,]* **Coventry Health Care** in accordance with state law and regulations promulgated by DIFP *[and made applicable to the plan by agreement and between the plan and DIFP pursuant to Technical Guidance from the U.S. Department of Health and Human Services dated September 23, 2010]. The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by UMR and Express Scripts Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time).*

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law.

6. Final external review decision. A final external review decision means a determination rendered under the *[DIFP]* external

review process at the conclusion of an external review.

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect;

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

C. The termination or discontinuance of coverage is effective retroactively at the request of the member in accordance with applicable provisions of this chapter regarding voluntary cancellation of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review *[by DIFP]* except as specifically provided in 22 CSR 10-2.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor who will have someone review the appeal who was not involved

in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First level appeals must be submitted in writing to—

UMR Claims Appeal Unit  
PO Box 30546  
Salt Lake City, UT 84130-0546

(b) Second level appeals must be sent in writing to—

UMR Claims Appeal Unit  
PO Box 8086  
Wausau, WI 54402-8086

(c) Expedited appeals must be communicated by calling UMR telephone 1-866-868-7758 or by submitting a written fax to 1-866-912-8464, Attention: Appeals Unit.

(VI) For members with medical coverage through *[Mercy Health Plans]* Coventry Health Care—

(a) First and second level appeals must be submitted in writing to—

*[Mercy Health Plans]*  
Attn: Corporate Appeals  
14528 S. Outer 40 Road, Suite 300  
Chesterfield, MO 63017  
Coventry Health Care  
Attn: Appeals Department  
550 Maryville Centre, Ste. 300  
St. Louis, MO 63141

(b) Expedited appeals must be communicated by calling *[Mercy Health Plans]* Coventry Health Care telephone *[1-800-830-1918, ext. 2394]* 1-314-214-2394 or by submitting a written fax to 1-314-214-3233, Attention: Corporate Appeals.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member claimant attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the claimant believes the claim should be paid, and any other written documentation to support the claimant's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts  
*[Clinical Appeals—MH3]*  
6625 West 78th Street, BLO390

**Attn: Pharmacy Appeals—MH3**  
**Mail Route 0390**  
**6625 W. 78th St.**  
Bloomington, MN 55439  
or by fax to 1-877-852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

**(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.**

**(II) The claimant can submit an external review request in writing to—**

**Office of Consumer Information and Oversight**  
**Department of Health and Human Services**  
**PO Box 791**  
**Washington DC 20044**  
or by fax to 1-202-606-0036  
or by email to [disputedclaim@opm.gov](mailto:disputedclaim@opm.gov)

**(III) The claimant may call the toll-free number 1-877-549-8152 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.**

**(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.**

**(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.**

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

**[(4)](5)** Except as otherwise expressly provided in this rule, appeals of adverse determinations made by MCHCP may be appealed to the board by fax or letter to the following address:

**Attn: Appeal**  
**Board of Trustees**  
**Missouri Consolidated Health Care Plan**  
**PO Box 104355**  
**Jefferson City, MO 65110**

**[(5)](6)** In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines.

(A) Newborns—If a member currently has coverage under the

plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within three (3) months of the child's date of birth.

(B) Agency error—MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office, *[the]* MCHCP, or plan offered by MCHCP that was no fault of the member.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year. **Plan changes are effective February 1. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

(D) Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).

(E) Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.

(F) Termination dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January. **If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, termination may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

(G) Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for the public entity (county or state) to provide subscriber with requested documentation.

(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage. **If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

(I) Loss of coverage notice—MCHCP may approve late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

(J) *[Wellness Program]* **Lifestyle Ladder** participation—MCHCP may deny all appeals regarding continuation of participation in the *[Wellness]* **Lifestyle Ladder** Program due to failure of member's participation.

(K) Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.

(L) Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.

(M) New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. **If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-2.090 Pharmacy Benefit Summary.** The Missouri Consolidated Health Care Plan is deleting sections (2), (4), and (8); amending the purpose, sections (1), (5), and (7); adding sections (6)–(8); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the PPO 300 Plan, PPO 600 Plan, HDHP with HSA, and Medicare Supplement Plans of the Missouri Consolidated Health Care Plan.*

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the PPO 300, PPO 600, HDHP with HSA, and Medicare Supplement Plans of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) The pharmacy benefit provides coverage for prescription drugs. [listed on the formulary, as described in the following:] Vitamins and nutrients coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a physician.

(A) [Medications.] PPO 300, PPO 600, and Medicare Supplement Plan Prescription Drug Coverage.

1. Retail—Network:

A. Generic: Eight-dollar (\$8) copayment for up to a thirty (30)-day supply for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%);

B. Brand: Thirty-five-dollar (\$35) copayment for up to a thir-

ty (30)-day supply for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%);

C. Non-formulary: One hundred dollar (\$100) copayment for up to a thirty (30)-day supply for a drug not on the formulary;

[C./D. [Mail order] Home delivery program—

(I) [Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for a twenty-dollar (\$20) copayment for a generic drug on the formulary or a eighty-seven-dollar-and-fifty-cent (\$87.50) copayment for a brand drug on the formulary.] Maintenance prescriptions may be filled through the home delivery program. Some medications may not qualify for the program because they require prior authorization or quantity level limits.

(a) Generic: Twenty dollar (\$20) copayment for up to a ninety (90)-day supply for a generic drug on the formulary.

(b) Brand: Eighty-seven dollars and fifty cent (\$87.50) copayment for up to a ninety (90)-day supply for a brand drug on the formulary.

(c) Non-formulary: Two hundred fifty dollar (\$250) copayment for up to a ninety (90)-day supply for a drug not on the formulary; and

(II) Specialty drugs covered only through network [mail order] home delivery for up to thirty (30) days. [Copayments—] The first specialty prescription order may be filled through a retail pharmacy.

(a) Generic: [e/E]ight dollars (\$8) for generic drug on the formulary list[; and].

(b) Brand: [t/Thirty-five dollars (\$35) for brand drug on the formulary.

(c) Non-formulary: One hundred dollar (\$100) copayment for a drug not on the formulary;

E. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

F. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment;

G. If the physician allows for generic substitution and the member chooses a brand name drug, the member is responsible for the generic copayment and the cost difference between the brand name and generic drug; and

H. Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary.

2. [Non-network pharmacies] Retail—Non-network:[—] If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. [S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable copayment or coinsurance. All such claims must be filed within twelve (12) months of the incurred expense.] The pharmacy plan administrator will reimburse the cost of the drug based on the network discounted amount, less the applicable copayment.

A. Generic: Eight dollar (\$8) copayment for up to a thirty (30)-day supply for a generic drug on the formulary.

B. Brand: Thirty-five dollar (\$35) copayment for up to a thirty (30)-day supply for a brand drug on the formulary.

C. Non-formulary: One hundred dollar (\$100) copayment for up to a thirty (30)-day supply for a drug not on the formulary.

[3. Retail prescription drugs—Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single

*dosage amount.]*

**(B) High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Prescription Drug Coverage.**

**1. Retail—Network:**

**A. Generic:** Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary; tobacco cessation prescriptions covered at one hundred percent (100%);

**B. Brand:** Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary; tobacco cessation prescriptions covered at one hundred percent (100%);

**C. Non-formulary:** Thirty percent (30%) coinsurance after deductible for a drug not on the formulary;

**D. Home delivery program.**

**(I) Maintenance prescriptions may be filled through the home delivery program. Some medications may not qualify for the program because they require prior authorization or quantity level limits.**

**(a) Generic:** Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary.

**(b) Brand:** Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

**(c) Non-formulary:** Thirty percent (30%) coinsurance after deductible for a drug not on the formulary.

**(II) Specialty drugs covered only through network home delivery for up to thirty (30) days.**

**(a) Generic:** Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary.

**(b) Brand:** Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

**(c) Non-formulary:** Thirty percent (30%) coinsurance after deductible for a drug not on the formulary; and

**E. Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary through the pharmacy benefit.**

**2. Retail—Non-network:** If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. The pharmacy plan administrator will reimburse the cost of the drug based on the network discounted amount, less the applicable deductible or coinsurance.

**A. Generic:** Forty percent (40%) coinsurance after deductible for up to a thirty (30)-day supply for a generic drug on the formulary.

**B. Brand:** Forty percent (40%) coinsurance after deductible for up to a thirty (30)-day supply for a brand drug on the formulary.

**C. Non-formulary:** Fifty percent (50%) coinsurance after deductible for up to a thirty (30)-day supply for a drug not on the formulary.

*[(2) If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment.]*

*[(3)](2) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first step drug, the physician may request a prior authorization from the pharmacy plan administrator. If the prior authorization is approved, the member is responsible for the applicable copayment which may be higher than the first step drug. If the*

*requested prior authorization is not approved, then the member is responsible for the full price of the drug.*

**(A) First Step—**

1. Uses primarily generic drugs;

2. Lowest applicable copayment is charged; and

3. First step drugs must be used before the plan will authorize payment for second step drugs.

**(B) Second Step—**

1. This step applies if the member's treatment plan requires a different medication after attempting the first step medication;

2. Uses primarily brand-name drugs; and

3. Typically, a higher copayment amount is applicable.

*[(4) Prior Authorization—Certain medications are subject to prior authorization. Network pharmacies will notify the member if prior authorization is required. The member or the pharmacy must contact the pharmacy plan administrator before payment will be approved.]*

*[(5)](3) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan administrator. In order to file a claim, members must—*

**(A) Complete the claim form; [and]**

**(B) Attach a prescription receipt or label with the claim form.** Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions, except diabetic supplies. If attaching a receipt or label, the receipt or label shall include:

1. Pharmacy name and address;

2. Patient's name;

3. Price;

4. Date filled;

5. Drug name, strength, and national drug code (NDC);

6. Prescription number;

7. Quantity; and

8. Days' supply./.; and

**(C) Members must file a claim to receive reimbursement of the cost of a prescription filled at a non-network pharmacy. Non-network pharmacy claims are allowed at the network discounted price as determined by the vendor minus any applicable copayment. Members are responsible for any charge over the network discounted price and the applicable copayment.**

*[(6)](4) Formulary—The formulary is updated on a semi-annual basis, or when—*

**(A)** A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; or

**(B)** A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; or

**(C)** A drug is determined to have a safety issue.

*[(7)](5) [Limitation—Prescription drugs not listed on the formulary are not a covered benefit except for prescription drugs that have been grandfathered for members who have taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011. If the participant purchased a brand-name drug that is grandfathered when there is a Food and Drug Administration (FDA)-approved generic drug, the participant shall pay the generic copayment plus the difference in the brand and generic cost of the drug.]*

**Grandfathered Specialty Drugs—Prescription drugs grandfathered for members in 2011 because they had taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011, will continue to be covered at a thirty-five dollar (\$35) brand copayment level if enrolled in a PPO plan or at twenty percent (20%) coinsurance if enrolled in the HDHP plan. Grandfathered drugs include:**

- (A) Alzheimer's disease drugs;
- (B) Antidepressants, including selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and norepinephrine reuptake inhibitors (SNRIs);
- (C) Anti-epileptics;
- (D) Attention-deficit hyperactivity disorder (ADHD);**
- [(D)](E) Biologics for inflammatory conditions;**
- [(E)](F) Cancer drugs;**
- [(F)](G) Hemophilia drugs [(F)]factor VIII and IX concentrates;**
- [(G)](H) Hepatitis drugs;**
- [(H)](I) Immunosuppressants (transplant anti-rejection agents);**
- [(I)](J) Insulin (basal);**
- [(J)](K) Low molecular weight heparins;**
- [(K)](L) Multiple sclerosis injectable drugs;**
- [(L)](M) Novel psychotropics (oral products and long-acting injectables);**
- [(M)](N) Phosphate binders;**
- [(N)](O) Pulmonary hypertension drugs; and**
- [(O)](P) Somatostatin analogs.**

*[(8) Under the High Deductible Health Plan (HDHP), pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.]*

**(6) Medicare Part B Prescription Drugs—**For covered Medicare Part B prescriptions, Medicare and MCHCP will coordinate to provide up to one hundred percent (100%) coverage for the drugs. To receive Medicare Part B prescriptions without a copayment or coinsurance, the subscriber must submit prescriptions and refills to an MCHCP vendor-contracted participating Medicare Part B retail pharmacy or use the MCHCP vendor-contracted home delivery service. Medicare Part B prescriptions include, but are not limited to, the following:

- (A) Diabetes testing and maintenance supplies;
- (B) Respiratory agents;
- (C) Immunosuppressants; and
- (D) Oral anti-cancer medications.

**(7) Quantity Level Limits—**Quantities of some medications may be limited based on recommendations by the Food and Drug Administration and medical literature. Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.

**(8) Guidelines for Drug Use—**If MCHCP suspects drug misuse, abuse, or fraud, MCHCP reserves the right to pay only for those medications prescribed by an assigned physician approved by MCHCP.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective June 30, 2006. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-2.091 Wellness Program Coverage, Provisions, and Limitations.** The Missouri Consolidated Health Care Plan is amending sections (1)–(4).

**PURPOSE:** *This amendment changes the policy of the board of trustees in regard to the wellness program.*

**EMERGENCY STATEMENT:** *This emergency amendment must be in place by November 25, 2011, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective November 25, 2011, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective November 25, 2011, and expires May 22, 2012.*

(1) Eligibility—*[All non-Medicare primary active, retiree, terminated vested, long term disability (LTD), survivor, and Consolidated Omnibus Budget Reconciliation Act (COBRA) subscribers and their non-Medicare primary spouses enrolled in a Missouri Consolidated Health Care Plan (MCHCP) medical plan may participate in the wellness program.] All Missouri Consolidated Health Care Plan (MCHCP) subscribers and covered spouses who do not have the TRICARE Supplement Plan or Medicare as primary coverage are eligible. Each eligible member must participate separately.*

(A) *[Members] Eligible members* may begin participating on or after their eligibility date or during the open enrollment (OE) period.

(2) Limitations and Exclusions.

**(C) Dependent children who are covered under a parent's plan and who are also state employees are not eligible to participate.**

**[(C)](D)** Members must have a Social Security number on file with MCHCP to be eligible to participate.

**[(D)](E)** When Medicare becomes a subscriber's primary insurance payer, the subscriber and participating spouse are no longer eligible to participate and will lose the wellness premium.

**[(E)](F)** When Medicare becomes a spouse's primary insurance payer, the spouse is no longer eligible to participate and will lose the wellness premium. The non-Medicare subscriber may continue to participate in the program.

(3) Participation. Members earn points through successful completion of activities as specified in the wellness program web portal through myMCHCP.

(A) The wellness program is *[voluntary]* called **Lifestyle Ladder**.

**(B) The Lifestyle Ladder program is voluntary.**

*[(B)](C)* Members are responsible for enrolling, participating, and completing activities, as well as keeping track of their applicable deadlines and points.

*[(C)](D)* Each activity has different enrollment, participation, and completion criteria.

1. Some activities require use of the Internet and/or a unique email address.

2. The vendor will make all determinations regarding activity enrollment, participation, and completion.

3. The vendor will award all points upon completion of an activity.

4. Completion of activities outside of the wellness participation period may result in points being applied to the next wellness participation period.

5. Members with disabilities may request special accommodations in writing to the vendor regarding activity participation.

*[(D)](E)* The required HA must be completed annually before points begin accruing.

*[(E)](F)* Points are assigned by the vendor in the wellness participation period in which they are earned by the participating member.

*[(F)](G)* The wellness participation period is the time frame in which activities must be completed in order to earn the wellness premium. The wellness participation periods are as follows: *[October 1–December 25; January 1–March 25; April 1–June 25; and July 1–September 25]* **October 1–November 25; December 1–February 25; March 1–May 25; and June 1–August 25.**

*[(G)](H)* The wellness coverage period is the time frame in which members receive the wellness premium for participation. The wellness coverage periods are as follows: January 1–March 31; April 1–June 30; July 1–September 30; and October 1–December 31.

*[(H)](I)* MCHCP and/or the vendor may audit participation information for accuracy. Misrepresentation or fraud could lead to termination from the wellness program, loss of the wellness premium, and/or prosecution.

(4) **Wellness Premium.** Members qualify for the wellness premium as follows:

(B) Points are accumulated in and can be monitored by the participating member from the wellness program web portal accessed through myMCHCP or by calling the vendor; and

(C) Members reaching the minimum one hundred (100)-point threshold per wellness participation period will receive the wellness premium **(fifteen dollars (\$15) off his or her monthly premium)** in the future wellness coverage period.

1. Members earning over one hundred (100) points in a given wellness participation period will receive the wellness premium in the future wellness coverage period, and all points over one hundred (100) will roll forward to be applied toward meeting the one hundred (100)-point threshold during the next wellness participation period.

2. Members not earning at least one hundred (100) points in a given wellness participation period will not receive the wellness premium for the future wellness coverage period, but the points earned totaling less than one hundred (100) will roll forward to be applied toward meeting the one hundred (100)-point threshold during the next wellness participation period.

3. A maximum of four hundred (400) points per wellness participation year is possible.

4. All earned points zero out at the end of the wellness participation year; and/.

*[(D)]* **The wellness premium will be applied to subscriber paychecks or retiree benefit checks at the beginning of each wellness coverage period.]**

**AUTHORITY:** section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 20, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Nov. 25, 2011, expires May 22,

2012. A proposed amendment covering this same material is published in this issue of the *Missouri Register*.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY RULE**

**22 CSR 10-2.094 Tobacco-Free Incentive Provisions and Limitations**

**PURPOSE:** *This rule establishes the policy of the board of trustees in regard to the tobacco-free incentive benefit.*

**EMERGENCY STATEMENT:** *This emergency rule must be in place by November 25, 2011, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule in order to maintain the integrity of the current health care plan. This emergency rule must become effective November 25, 2011, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the Missouri Register. This emergency rule complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed November 1, 2011, becomes effective November 25, 2011, and expires May 22, 2012.*

(1) **Eligibility**—All Missouri Consolidated Health Care Plan (MCHCP) subscribers and covered spouses who do not have the TRICARE Supplement Plan or Medicare as primary coverage are eligible. A spouse of a Medicare primary employee who is a retiree, long-term disability (LTD), or survivor may not participate in the tobacco-free incentive regardless of the spouse's Medicare eligibility status. Each eligible member must participate separately.

(A) Eligible members must attest when they become eligible for coverage or during the open enrollment period to receive the incentive.

(B) Eligible members with a break in coverage within the same plan year must complete the tobacco-free attestation by fax or mail.

(2) **Limitations and Exclusions.**

(A) Dependent children are not eligible to receive the incentive.

(B) Dependent children who are covered under a parent's plan and who are also state employees are not eligible to receive the incentive.

(C) When Medicare becomes a subscriber's primary insurance payer, the subscriber and participating spouse are no longer eligible to receive the incentive.



(D) When Medicare becomes a spouse's primary insurance payer, the spouse is no longer eligible to receive the incentive. The non-Medicare subscriber may continue to receive the incentive.

(3) Incentive Participation Requirement.

(A) To receive the incentive beginning on January 1, 2012, eligible members must do one (1) of the following:

1. Tobacco-free attestation.

A. The member must complete a tobacco-free attestation online through myMCHCP or submit a completed form by fax or mail during the period of October 1, 2011, through November 25, 2011. The form must be received by November 25, 2011; or

2. Tobacco cessation program attestation.

A. Participate in an MCHCP approved tobacco cessation program as defined in section (3) and complete a tobacco cessation program attestation online through myMCHCP or submit a completed form by fax or mail during the period of October 1, 2011, through November 25, 2011. The form must be received by November 25, 2011.

(I) If a subscriber and his/her spouse become and remain tobacco-free three (3) months prior to May 25, 2012, s/he may continue to receive the incentive through December 31, 2012, if s/he completes a tobacco-free attestation through myMCHCP or submit a completed form by fax or mail by May 25, 2012. The form must be received by May 25, 2012.

(B) For a new employee or an employee added during a special enrollment period and his/her spouse to receive the incentive from the employee's effective date of coverage, the employee must complete a tobacco-free attestation or tobacco cessation program attestation at the time of enrollment. A covered spouse's attestation must be completed within thirty-one (31) days of enrollment. If a subscriber and/or his/her spouse complete the tobacco cessation program attestation and become and remain tobacco-free three (3) months prior to May 25, 2012, s/he can continue to receive the incentive through December 31, 2012, if s/he completes a tobacco-free attestation through myMCHCP or submits a completed form by fax or mail by May 25, 2012. A form must be received by May 25, 2012. A new employee and spouse added during a special enrollment period after May 25, 2012, must complete the tobacco-free attestation form to receive the incentive within thirty-one (31) days of enrollment.

(C) A waiver may be granted if a member provides a physician certification that a medical condition prevents the member from achieving tobacco-free status.

(D) Eligible members with a break in coverage within the same plan year must again attest to be tobacco-free through an online attestation or submit a paper attestation form to MCHCP.

(E) If a member attests to be tobacco-free but starts to use tobacco products, he/she must contact MCHCP through myMCHCP or by phone, fax, or mail immediately to change his/her status. MCHCP will adjust his/her premium for coverage beginning the second month after the member self reports.

(F) MCHCP may audit the attestation for accuracy.

(4) MCHCP approved tobacco cessation programs are—

(A) StayWell Tobacco NextSteps: Phone coaching (866-564-5235);

(B) Missouri Tobacco Quitline: 800-QUIT-NOW (800-784-8669); or

(C) American Cancer Society Quit for Life (866-784-8454).

(5) MCHCP may utilize participation data for purposes of offering additional programs in accordance with the MCHCP privacy policy.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Nov. 1, 2011, effective Nov. 25, 2011, expires May 22, 2012. A proposed rule covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY RULE**

**22 CSR 10-2.095 TRICARE Supplement Plan**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the TRICARE Supplement Plan Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the Missouri Register. This emergency rule complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) TRICARE is the Department of Defense's health insurance program for the military community. Primary coverage is through TRICARE with the Missouri Consolidated Health Care Plan TRICARE Supplement Plan paying secondary on claims.

(A) TRICARE Supplement Plan design is defined and provided by the Association and Society Insurance Corporation (ASI).

(B) TRICARE Supplement Plan eligibility, enrollment, and termination requirements are determined by ASI.

(C) Total TRICARE Supplement Plan premium costs for all coverage levels are fully paid by the member and collected by the plan administrator.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rule covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**EMERGENCY RULE**



## 22 CSR 10-2.100 Fully-Insured Medical Plan Provisions

**PURPOSE:** This rule establishes the policy of the board of trustees in regard to the Fully-Insured Plan Provisions of the Missouri Consolidated Health Care Plan.

**EMERGENCY STATEMENT:** This emergency rule must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the *Missouri Register*. This emergency rule complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.

(1) A fully-insured medical plan is subject to applicable Department of Insurance, Financial Institutions and Professional Registration (DIFP) statutes and regulations. Members enrolled in a fully-insured medical plan will have rights and responsibilities as provided in those applicable statutes and regulations. If and to the extent there is a conflict between the plan and DIFP statutes and regulations, DIFP statutes and regulations shall prevail. Governing DIFP statutes and regulations include but are not limited to appeals, timelines, and payments.

**AUTHORITY:** section 103.059, RSMo 2000. Emergency rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rule covering this same material is published in this issue of the *Missouri Register*.

### Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

#### EMERGENCY AMENDMENT

**22 CSR 10-3.010 Definitions.** The Missouri Consolidated Health Care Plan is deleting sections (6), (8), (9), (11), (13), (16), (19), (21), (22), (24)–(26), (29)–(32), (34), (36), (39), (42), (47), (50)–(53), (55)–(58), (61), (62), (64)–(66), (70), (77)–(80), (82)–(85), (87)–(89), (92), (95), (98)–(103), (105), (109)–(111), (113), (114), (122)–(124), (126), (127), (129), and (131); amending sections (1), (3)–(5), (10), (14), (18), (23), (28), (33), (37), (38), (41), (43), (46), (48), (53), (69), (72), (74), (76), (81), (86), (93), (96), (97), (104), (112), (117), and (128); adding sections (7), (20),

(22), (28), (43), and (54); and renumbering as necessary.

**PURPOSE:** This amendment changes the policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan relative to public entities and public entity members.

**EMERGENCY STATEMENT:** This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the *Missouri Register*. This emergency amendment complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.

(1) Accident. An unforeseen and unavoidable event resulting in an injury [which is not due to any fault or misconduct on the part of the person injured].

(3) Administrative appeal. A written request submitted by or on behalf of a member involving plan-related administrative issues such as eligibility, effective dates of coverage, and plan changes[, etc].

(4) Adverse **benefit** determination. [When the claims administrator reviews an admission, availability of care, continued stay, or other health care service and decides that it is not medically necessary, appropriate, or effective. Therefore, payment for the requested service is denied, reduced, or terminated.] An adverse benefit determination means any of the following:

(A) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit based on a determination of an individual's eligibility to participate in the plan;

(B) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, investigational, or not medically necessary or appropriate; or

(C) Rescission of coverage after an individual has been covered under the plan.

(5) Allowable [expense] amount. [Charges for services rendered or supplies furnished by a health plan that would qualify as

covered expenses and for which the program pays in whole or in part, subject to any deductible and coinsurance amounts.] **Maximum amount on which payment is based for covered health care services. This may be called eligible expense, payment allowance, or negotiated rate. If the provider charges more than the allowed amount, the member may be balance-billed. See balance billing, section (7).**

[(6)] **Appeal.** A written complaint submitted by or on behalf of a member regarding one (1) of the following:

(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claim payment, handling, or reimbursement for pharmacy benefits or health care services.]

[(7)] **(6) Applied behavior analysis.** The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior.

[(8)] **Assignment.** When a doctor agrees to accept Medicare's fee as full payment.

(9) **Benefit period.** The three hundred sixty-five (365) days immediately after the first date of the services to treat a given condition.]

**(7) Balance billing.** When a provider bills for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is one hundred dollars (\$100) and the allowed amount is seventy dollars (\$70), the provider may bill the member for the remaining thirty dollars (\$30). A network provider may not balance bill.

[(10)] **(8) Benefits.** [Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator.] **Health care services covered by the plan.**

[(11)] **Birthday rule.** If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.]

[(12)] **(9) Board.** The board of trustees of the Missouri Consolidated Health Care Plan (MCHCP).

[(13)] **Calendar year.** The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.]

[(14)] **(10) Cancellation of coverage.** The [voluntary cancellation] ending of medical, dental, or vision coverage per a subscriber's voluntary request.

[(15)] **(11) Case management.** A coordinated set of activities conducted for individual patient management of serious or complicated health conditions.

[(16)] **Chiropractic services.** The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward

restoring and maintaining the normal neuromuscular and musculoskeletal function and health.]

[(17)] **(12) Claims administrator.** An organization or group responsible for the processing of claims and associated services for a health plan.

[(18)] **(13) Coinsurance.** [The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.] **The member's share of the costs of a covered health care service, calculated as a percent (for example, twenty percent (20%)) of the allowed amount for the service. The member pays coinsurance plus any deductibles owed. For example, if the health insurance or plan's allowed amount for an office visit is one hundred dollars (\$100) and the member has met his/her deductible, the member's coinsurance payment of twenty percent (20%) would be twenty dollars (\$20). The health insurance or plan pays the rest of the allowed amount.**

[(19)] **Comprehensive major medical.** A plan that provides for cost sharing to be applied to all covered expenses, such as deductible or coinsurance.]

[(20)] **(14) Congenital defect.** Existing or dating from birth. Acquired through development while in the uterus.

[(21)] **Convenient care clinics (CCCs).** Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics."

(22) **Coordination of benefits.** Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.]

[(23)] **(15) Copayment.** [A set dollar amount that the covered individual must pay for specific services.] **A fixed amount for example, fifteen dollars (\$15) the member pays for a covered health care service, usually when the member receives the service. The amount can vary by the type of covered health care service.**

[(24)] **Cosmetic surgery.** A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than restore the anatomy and/or function of the body which are lost or impaired due to illness or injury.

(25) **Covered benefits and charges.** Covered benefits are a schedule of health care services payable under the plan. Covered charges are the cost for medical services eligible for consideration under the plan.

(26) **Custodial care.** Services and supplies furnished primarily to assist an individual to meet the activities of daily living that can be provided by persons without the training of a health care provider or that do not entail and require the continuing attention of trained medical or paramedical personnel.]

[(27)] **(16) Date of service.** Date medical services are received.

[(28)] **(17) Deductible.** [The amount of expense the member must pay before the plan begins to pay for covered services and supplies. This amount is not reimbursable by the plan.] **The amount the member owes for health care services that the health plan covers before the member's health plan begins to pay.**

For example, if the deductible is one thousand dollars (\$1,000), the member's plan will not pay anything until s/he meets his/her one thousand dollars (\$1,000) deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

[(29) *Dependent child.* Any child under the age of twenty-six (26) that is a natural child, legally adopted or placed for adoption child, or a child with one (1) of the following legal relationships with the member, so long as such legal relationship remains in effect:

- (A) Stepchild;
- (B) Foster child;
- (C) Grandchild for whom the employee has legal guardianship or legal custody; and
- (D) Other child for whom the employee is court-ordered legal guardian.

1. Except for a disabled child as described in 22 CSR 10-3.010(88), a dependent child is eligible from his/her eligibility date to the end of the month he/she attains age twenty-six (26).

2. A child who is a dependent child under a guardianship of a minor will continue to be a dependent child when the guardianship ends by operation of law when the child becomes eighteen (18) years of age if such child was an MCHCP member the day before the child becomes eighteen (18) years of age.

[(30) *Dependents.* The lawful spouse of the employee, the employee's unemancipated child(ren), and certain survivors of employees, as provided in the plan document and these rules, for whom application has been made and has been accepted for participation in the plan.

[(31) *Diagnostic.* Describes a procedure to determine whether a person has a particular illness.

[(32) *Diagnostic charges.* The Usual, Customary, and Reasonable (UCR) charges or the network discounted rate (NDR) for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.]

[(33)](18) *Disease management.* A program offered to [non-Medicare] members, who do not have primary Medicare coverage, to help manage certain chronic diseases.

[(34) *Disposable supplies.* Supplies that do not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.]

[(35)](19) *Doctor/physician.* A licensed practitioner of the healing arts, as approved by the plan administrator, including:

- (A) Doctor of medicine;
- (B) Doctor of osteopathy;
- (C) Podiatrist;
- (D) Optometrist;
- (E) Chiropractor;
- (F) Psychiatrist;
- (G) Psychologist;
- (H) Doctor of dental medicine, including dental surgery;
- (I) Doctor of dentistry; or
- (J) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

[(36) *Durable medical equipment (DME).* Equipment able to withstand repeated use for the therapeutic treatment of an

active illness or injury. Such equipment is not covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.]

(20) *Effective date.* The date on which coverage takes effect as described in 22 CSR 10-3.020(4).

[(37)](21) *Eligibility date.* The first day a member is qualified to enroll for coverage [A/as described in 22 CSR 10-3.020(2).

(22) *Eligibility period.* The time allowed to enroll in accordance with the rules in this chapter.

[(38)](23) *Emergency medical condition.* [A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(A) Conditions placing a person's health in significant jeopardy;

(B) Serious impairment to a bodily function;

(C) Serious dysfunction of any bodily organ or part;

(D) Inadequately controlled pain; or

(E) Situations when the health of a pregnant woman or her unborn child are threatened.] The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(A) Placing a person's health in significant jeopardy;

(B) Serious impairment to a bodily function;

(C) Serious dysfunction of any bodily organ or part;

(D) Inadequately controlled pain; or

(E) With respect to a pregnant woman who is having contractions—

1. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

2. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

[(39) *Emergency room.* The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.]

[(40)](24) *Emergency Services.* With respect to an emergency medical condition—

(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient. The term "to stabilize" means to provide such medical treatment of the condition as may be necessary to *assure/ensure*, within reasonable medical probability that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility.

[(41)](25) *Employee.* A benefit-eligible person employed by a participating public entity and present and future retirees from the participating public entity who meet the plan eligibility requirements [as prescribed by the participating public entity].

*[(42) Employee and dependent participation. Participation of an employee and the employee's eligible dependents. Any individual eligible for participation as an employee is not eligible as a dependent except as noted in 22 CSR 10-3.030(1)(A)7.]*

*[(43)](26) Employer. The public entity that employs the eligible employee [as defined above].*

*[(44)](27) Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:*

*(A) Ambulatory patient services—office visits, urgent care, outpatient diagnostic procedures, outpatient surgery, and outpatient hospice;*

*(B) Emergency services—ambulance services and emergency room services;*

*(C) Hospitalization—inpatient hospital benefits, inpatient surgery, transplants, and inpatient hospice;*

*(D) Maternity and newborn care—maternity coverage and newborn screenings;*

*(E) Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/chemical dependency office visits;*

*(F) Prescription drugs;*

*(G) Rehabilitative and habilitative services and devices—durable medical equipment; cardiac and pulmonary rehabilitation; outpatient physical, speech, and occupational therapy; and home health care/[palliative services];*

*(H) Laboratory services—lab and [x/X]-ray;*

*(I) Preventive and wellness services and chronic disease management; and*

*(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, immunizations, preventive services, and newborn screenings.*

**(28) Excluded services. Health care services that the member's health plan does not pay for or cover.**

*[(45)](29) Executive director. The chief executive officer of the Missouri Consolidated Health Care Plan (MCHCP) who shall have charge of the offices, records, and employees of the plan, subject to the direction of the board of trustees.*

*[(46)](30) Experimental/Investigational/Unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below and that the plan administrator determines, in the exercise of its discretion, is considered experimental/investigational/unproven and is not eligible for coverage under the plan/. *Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community. Experimental/investigational/unproven is defined as a treatment, procedure, device, or drug that the plan administrator determines, in the exercise of its discretion]*—*

*(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;*

*(B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or*

*(C) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its*

*efficiency as compared with the standard means of treatment or diagnosis.*

**(D) Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.**

*[(47) First eligible. The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first eligible period is the first thirty-one (31) days from the date of the lift event.]*

*[(48)](31) Formulary. A list of U.S. Food and Drug Administration approved drugs [covered] and supplies developed by the pharmacy benefit manager and [as allowed] covered by the plan administrator.*

*[(49)](32) Generic drug. A chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.*

*[(50) Group health plan. A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.*

*(51) Handbook. The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference is available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2011 Public Entity Member Handbook (March 15, 2011) or online at [www.mchcp.org](http://www.mchcp.org). It does not include any later amendments or additions.*

*(52) Health care benefit. Coverage under the plan to include medical, dental, vision, and pharmacy.]*

*[(53)](33) Health savings account (HSA). A tax-advantaged savings account that may be used to pay for current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. [HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.]*

*[(54)](34) High Deductible Health Plan (HDHP). A health plan with a higher deductible/s/ than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.*

*[(55) Home health care. Skilled nursing services and other therapeutic services to persons in their homes provided by an agency certified by Medicare and licensed pursuant to state or local law.*

*(56) Hospice. A public agency, private organization, or a subdivision of either that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.*

*(57) Hospice facility. A public or private organization, certified by Medicare and any other state's licensing or certifying*

*body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility, or part thereof, which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.*

**(58) Hospital.**

*(A) An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic, and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24)-hour-a-day nursing service by a registered nurse (RN) on duty or call.*

*(B) An institution not meeting all the requirements of subsection (58)(A) above, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.*

*(C) An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).*

*(D) A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.*

*(E) A residential alcoholism, chemical dependency, or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction.*

*(F) In no event shall the term hospital include a skilled nursing facility or any institution, or part thereof, which is used primarily as a skilled nursing facility, nursing home, rest home, or facility for the aged.]*

**[(59)](35) Illness.** Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered *[as any other]* an illness.

**[(60)](36) Incident.** A definite and separate occurrence of a condition.

**[(61) Infertility.** Any medical condition causing the inability or diminished ability to reproduce.

**(62) Infertility services.** Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.]

**[(63)](37) Injury.** A condition that results independently of an illness and all other causes and is a result of an external force or accident.

**[(64) Inpatient.** Confined to a registered bed. Patient in hospital, skilled nursing facility, hospice facility, or free-standing chemical dependency treatment center.

**(65) Life events.** Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.

**(66) Lifetime.** The period of time a member or the member's eligible dependents participate in the plan.]

**[(67)](38) Lifetime maximum.** The amount payable by a medical plan during a covered member's life for specific non-essential benefits.

**[(68)](39) MCHCPid.** An individual MCHCP member identifier used for member verification and validation.

**[(69)](40) myMCHCP.** A secure MCHCP member website that *[includes coverage selection, level of coverage, an option to change a mailing address, an option to add or change an email address, an option to request an MCHCPid card, and access to other pertinent websites]* allows members to review coverage selections, verify covered dependents, make coverage changes, add/change email address, and access health plan websites.

**[(70) Medical benefits coverage.** Services that are received from providers recognized by the plan and are covered benefits under the plan.]

**[(71)](41) Medically necessary.** Treatments, procedures, services, or supplies that the plan administrator determines, in the exercise of its discretion—

(A) Are expected to be of clear clinical benefit to the patient;

(B) Are appropriate for the care and treatment of the injury or illness in question; and

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.

**[(72)](42) Medicare [allowed]-approved amount.** The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a *[doctor or]* health care provider.

**(43) Medicare assignment.** When a health care provider agrees to accept the Medicare-approved amount as payment in full for claims.

**[(73)](44) Member.** Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

**[(74) Network provider.** A physician, hospital, pharmacy, or other health provider that is contracted with the plan or its designee.]

**(45) Network.** The facilities, providers, and suppliers the health insurer or plan has contracted with to provide health care services.

**[(75)](46) Non-formulary.** A drug not contained on the pharmacy benefit manager's list of covered drugs.

**[(76)](47) Non-network [provider or non-participating provider.** Any physician, hospital, pharmacy, or other health provider that does not have a contract with the plan or its designee]. The facilities, providers, and suppliers the health plan does not contract with to provide health care services.

**[(77) Nurse.** A registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule.

*(78) Nursing home. An institution operated, pursuant to law, primarily for custodial care or for patients recovering from illness or injury, under the supervision of a physician or registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations that are recognized under Medicare.*

*(79) Open enrollment period. A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year.*

*(80) Out-of-area. Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria.]*

*[(81)](48) Out-of-pocket maximum. [The annual limit on the amount a member must pay for covered services. Above this limit, the medical plan pays one hundred percent (100%) for covered services for the rest of the plan year.] The most the member will pay during a plan year before the plan begins to pay one hundred percent (100%) of the allowed amount. This limit never includes the member's premium, copayments, balance-billed charges, or health care services the plan does not cover.*

*[(82) Outpatient. Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.*

*(83) Outpatient observation stay. Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.*

*(84) Palliative services. Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.*

*(85) Partial hospitalization. A distinct and organized intensive ambulatory treatment service, less than twenty-four (24)-hour daily care specifically designed for the diagnosis and active treatment of a mental/nervous disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.*

*(A) Partial hospitalization programs must provide diagnostic services; services of social workers; nurses and staff trained to work with psychiatric patients; individual, group, and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions.*

*(B) The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a physician.]*

*[(86)](49) [Any employee or dependent accepted for mem-*

*bership in the plan.] Participant. Shall have the same meaning as the term member defined herein. See member, section (44).*

*[(87) Pharmacy benefit manager (PBM). The PBM designs, implements, and manages the overall drug benefit of the plan and processes claims payments.*

*(88) Physically or mentally disabled. A person's inability to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition.*

*(89) Physician/Doctor. A licensed practitioner of the healing arts, acting within the scope of his/her practice, as licensed under section 334.021, RSMo.]*

*[(90)](50) Plan. The program of health care benefits established by the board of trustees of the Missouri Consolidated Health Care Plan as authorized by state law.*

*[(91)](51) Plan administrator. The board of trustees of the Missouri Consolidated Health Care Plan, which is the sole fiduciary of the plan. The board has all discretionary authority to interpret its provisions and to control the operation and administration of the plan and whose decisions are final and binding on all parties.*

*[(92) Plan document. The statement of the terms and conditions of the plan as promulgated by the plan administrator in this chapter.]*

*[(93)](52) Plan year. The [calendar year beginning] period of January 1 through December 31. [This is the period during which the total amount of annual benefits is calculated. All deductibles and benefit maximums accumulate during the calendar year.]*

*[(94)](53) Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to plan members. Benefits are paid at a higher level when network providers are used.*

*(54) Premium. The monthly amount that must be paid for health insurance.*

*[(95) Preventive service. A procedure intended for avoidance or early detection of an illness.]*

*[(96)](55) Primary care physician (PCP). [A physician (usually a/an internist, family/general practitioner, or pediatrician/) who has contracted with a medical plan].*

*[(97)](56) Prior authorization. [A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service. Also known as pre-authorization or pre-notification.] A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called pre-authorization, prior approval, or precertification. The plan may require prior authorization for certain services before the member receives them, except in an emergency. Prior authorization is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request prior authorization.*

*[(98) Private duty nursing. Nursing care on a full-time basis in the member's home or home health aides.*

*(99) Proof of eligibility. Documentation required by the plan to determine a dependent's qualification for health insurance coverage.*

*(100) Proof of prior group insurance. Evidence in written form from an insurance company that provides verification of coverage for a given period of time.*

*(101) Proof of prior coverage. If a member or his/her dependents enroll in an MCHCP plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:*

- (A) Date coverage was or will be terminated;*
- (B) Reason for coverage termination; and*
- (C) List of dependents covered.*

*(102) Prostheses. An artificial extension that replaces a missing part of the body or supplements defective parts.*

*(103) Protected health information (PHI). Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.]*

*[(104)](57) Provider. A physician, hospital, medical agency, specialist, or other duly-/licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-3.010/[(35)](19). Other providers include but are not limited to:*

- (A) Audiologist (AUD or PhD);*
- (B) Certified Addiction Counselor for Substance Abuse (CAC);*
- (C) Certified Nurse Midwife (CNM)—when acting within the scope of [their] his/her license in the state in which [they] s/he practice and performing a service which would be payable under this plan when performed by a physician;*

*(D) Certified Social Worker or Masters in Social Work (MSW);*

***(E) Chiropractor;***

*[(E)](F) Licensed Clinical Social Worker;*

*[(F)](G) Licensed Professional Counselor (LPC);*

*[(G)](H) Licensed Psychologist (LP);*

*[(H)](I) Nurse Practitioner (NP);*

*[(I)](J) Physician/s/ Assistant (PA);*

*[(J)](K) [Qualified] Occupational Therapist;*

*[(K)](L) [Qualified] Physical Therapist;*

*[(L)](M) [Qualified] Speech Therapist;*

*[(M)](N) Registered Nurse Anesthetist (CRNA);*

*[(N)](O) Registered Nurse Practitioner (ARNP); or*

*[(O)](P) Therapist with a PhD or Master's Degree in Psychiatry or related field.*

*[(105) Provider directory. A listing of network providers within a health plan.]*

*[(106)](58) Prudent layperson. An individual possessing an average knowledge of health and medicine.*

*[(107)](59) Public entity. A state-sponsored institution of higher learning, political subdivision, or governmental entity or instrumentality that has elected to join the plan and has been accepted by the board.*

*[(108)](60) Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or member if the plan normally provides coverage for dependent children.*

*[(109) Reconstructive surgery. A procedure performed to restore the anatomy and/or functions of the body that are lost or impaired due to an injury or illness.*

*(110) Refractions. A record of the patient's preference for the focusing of the eyes that may then be used to purchase eyeglasses or contact lenses. It is the part of the exam that determines what prescription lens gives the patient the best possible vision.*

*(111) Rehabilitation facility. A legally operating institution, or distinct part of an institution, that has a transfer agreement with one (1) or more hospitals and is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital, and rehabilitative inpatient care, and is duly licensed by the appropriate government agency to provide such services.*

*(A) It does not include institutions that provide only minimal care, custodial care, ambulatory or part-time care services, or an institution that primarily provides treatment of mental/nervous disorders, substance abuse, or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission for the Accreditation of Rehabilitation Facilities.]*

*[(112)](61) Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-3.020/[(6)](B)/(2)(D) and is currently receiving a monthly retirement benefit from a public entity.*

*[(113) Skilled nursing care. Services that must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.*

*(114) Skilled nursing facility (SNF). A public or private facility licensed and operated according to the law that provides—*

*(A) Permanent and full-time facilities for ten (10) or more resident patients;*

*(B) A registered nurse or physician on full-time duty in charge of patient care;*

*(C) At least one (1) registered nurse or licensed practical nurse on duty at all times;*

*(D) A daily medical record for each patient;*

*(E) Transfer arrangements with a hospital; and*

*(F) A utilization review plan.*

*The facility must be primarily engaged in providing continuous skilled nursing care for persons during the recovery stage of their illness or injury, and is not, other than by coincidence, a rest home for custodial care or for the aged.]*

*[(115)](62) Sound natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.*

*[(116)](63) Specialty care physician/specialist. A physician who is*



not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

[(117)](64) Specialty medications. High cost drugs that [are primarily self-injectible but sometimes oral medications] treat chronic complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis.

[(118)](65) State. Missouri.

[(119)](66) Step therapy. Designed to encourage use of therapeutically-equivalent, lower-cost alternatives before using more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

[(120)](67) Subrogation. The substitution of one (1) "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the [participant] member and recover the money directly from the other insurer.

[(121)](68) Subscriber. The employee or member who elects coverage under the plan.

[(122)] Surgery. Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.

[(123)] Surgery center (ambulatory). A hospital-based, hospital-sponsored, or independently-owned facility that performs surgery.

[(124)] Survivor. A member who meets the requirements of subsection 22 CSR 10-3.020(6)(A).]

[(125)](69) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

[(126)] Urgent care. Medically necessary services in order to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.

[(127)] Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.]

[(128)](70) Usual, [C]customary, and [R]reasonable [charge]. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

[(A) Usual—The fee a provider most frequently charges the majority of his/her patients for the same or similar services.

[(B) Customary—The range of fees charged in a geographic area by providers of comparable skills and qualifications for the same performance of similar service.

[(C) Reasonable—The flexibility to take into account any unusual clinical circumstances involved in performing a particular service.

[(D) A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the providers for ninety percent (90%) of the procedures reported.

[(129)] Utilization review. Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a prospective, concurrent, or retrospective basis.]

[(130)](71) Vendor. The current applicable third-party administrators of MCHCP benefits.

[(131)] Vested subscriber. A member who meets the requirements of subsection 22 CSR 10-3.020(6)(B).]

*AUTHORITY:* section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the *Code of State Regulations*. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the *Missouri Register*.

## **Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership**

### **EMERGENCY RESCISSION**

**22 CSR 10-3.020 Subscriber Agreement and General Membership Provisions.** This rule established the policy of the board of trustees in regard to the subscriber agreement and general membership provisions of the Missouri Consolidated Health Care Plan.

*PURPOSE:* This rule is being rescinded and readopted to include detailed language to clarify general membership provisions.

*EMERGENCY STATEMENT:* This emergency rescission must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rescission is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the *Missouri Register*. This emergency rescission complies

with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rescission was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.

**AUTHORITY:** section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the *Code of State Regulations*. Emergency rescission filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rescission covering this same material is published in this issue of the *Missouri Register*.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY RULE**

**22 CSR 10-3.020 General Membership Provisions**

**PURPOSE:** This rule establishes the policy of the board of trustees in regard to the general membership provisions of the *Missouri Consolidated Health Care Plan*.

**EMERGENCY STATEMENT:** This emergency rule must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, officers, and their families) enrolled in the *Missouri Consolidated Health Care Plan (MCHCP)* from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the *Missouri Consolidated Health Care Plan Board of Trustees*. A proposed rule, which covers the same material, is published in this issue of the *Missouri Register*. This emergency rule complies with the protections extended by the *Missouri and United States Constitutions* and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.

(1) **Terms and Conditions.** The following rules provide the terms and conditions for membership in the *Missouri Consolidated Health Care Plan (MCHCP)*. Public entities and members are required to provide complete, true, and accurate information to MCHCP in connection with enrollment, change, or cancellation processes, whether by online, written, or verbal communication. MCHCP may rely on, but reserves the right to audit, any information provided by a public entity or member and seek recovery and/or pursue legal action to the

extent the public entity or member has provided incomplete, false, or inaccurate information.

(2) **Eligibility Requirements.**

(A) **Employee and Dependent Eligibility Requirements.** Health plans contracted with MCHCP must be made available to all eligible employees, their dependents, and retirees of the public entity. An eligible employee is one who is actively employed and meets the minimum number of hours worked per year as established by his/her employer. If the public entity allows elected/appointed officials to participate in medical coverage, the definition of an employee includes elected/appointed officials where applicable. The entity will determine the eligibility requirements of waiting periods, required number of working hours, pay status, and contribution levels.

(B) An employee cannot be covered as an employee and as a dependent.

1. An eligible employee may enroll eligible dependents as long as the eligible employee is also enrolled. Eligible dependents include:

A. Spouse.

(I) A public entity retiree may enroll as a spouse under an employee's coverage or elect coverage as a retiree.

(II) If one spouse is a state employee with MCHCP benefits and the other is a public entity employee with MCHCP benefits, each spouse may enroll under his or her employer's plan or together under one employer's plan. The spouses cannot have coverage in both places; and

B. Children.

(I) Children may be covered through the end of the month in which they turn twenty-six (26), if they meet one of the following criteria:

(a) Natural child of subscriber or spouse;

(b) Legally adopted child of subscriber or spouse;

(c) Child legally placed for adoption of subscriber or spouse;

(d) Stepchild of subscriber or spouse;

(e) Foster child of subscriber or spouse;

(f) Grandchild for whom the covered subscriber or covered spouse has legal guardianship or legal custody;

(g) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years of age if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years of age;

(h) Newborn of a subscriber or a covered dependent;

(i) Child for whom the subscriber or covered spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or

(j) Child who is twenty-six (26) or older and is permanently disabled in accordance with subsection (5)(C) only if such child was an MCHCP member the day before the child turned twenty-six (26).

(II) A child may only be covered by one (1) parent if his/her parents are married and are both covered under an MCHCP medical plan.

(III) A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. MCHCP will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both

subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time.

(C) Changes in Dependent Status. If a covered dependent loses his/her eligibility, the public entity and subscriber must notify MCHCP within thirty-one (31) days to terminate his/her coverage effective the end of the month eligibility ceases.

(D) Retiree and Dependent Eligibility Requirements. A retiree and his/her dependents will remain eligible as long as the entity remains with MCHCP.

1. To enroll or continue coverage at retirement, the employee and his/her dependents must provide all of the following:

A. Submit a completed enrollment form within thirty-one (31) days of retirement date. Coverage is effective on retirement date.

(I) Submit proof of prior coverage and proof of eligibility for dependents if s/he and his/her dependents choose to enroll in an MCHCP plan at retirement and have had other insurance coverage for six (6) months immediately prior to his/her retirement.

2. Employees may continue coverage on their eligible dependents into retirement.

3. A retiree may only add dependents to his/her coverage when—

A. A life event occurs; or

B. A dependent's employer-sponsored coverage ends due to one (1) of the following, provided that the dependent's employer-sponsored coverage was in place for twelve (12) months immediately prior to the loss, and MCHCP coverage is requested within sixty (60) days of the termination date of the previous coverage:

(I) Termination of employment;

(II) Retirement; or

(III) Termination of group coverage by the employer.

4. A retiree and/or his/her dependents may continue dental and/or vision coverage into retirement without medical coverage.

### (3) Enrollment Procedures.

(A) New Employee. The public entity must enroll or waive coverage by submitting the appropriate enrollment form signed by the employee within thirty-one (31) days of his/her eligibility date. A new employee's coverage begins on the first day of the month after the hire date and the applicable waiting period.

#### (B) Open Enrollment.

1. An employee may elect coverage and/or change coverage levels during the annual open enrollment period if one (1) of the following occurred:

A. Waived his/her right to insurance when first eligible;

B. Did not enroll eligible dependents when first eligible; or

C. Dropped his/her or dependent coverage during the year.

2. A retiree may change from one medical plan to another during open enrollment but cannot add a dependent. If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in a plan during open enrollment.

#### (C) Special Enrollment Periods.

1. An employee may apply for coverage for himself/herself or for his/her dependents if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of adopted children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. An employee and his/her dependents may enroll within sixty (60) days if s/he involuntarily loses employer-sponsored coverage under one (1) of the following circumstances, and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. A retiree may apply for dependent coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of adopted children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her dependent within sixty (60) days if the dependent involuntarily loses employer-sponsored coverage under one (1) of the following circumstances. Dependent employer-sponsored coverage must be in place for twelve (12) months immediately prior to the loss, and MCHCP coverage must be requested within sixty (60) days of the termination date of the previous coverage:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. MO HealthNet or Medicaid status loss. If an employee who is not retired, survivor, or his/her dependent loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss.

4. Qualified Medical Child Support Order. If a subscriber receives a court order stating s/he is responsible for coverage of dependent, the subscriber may enroll the dependent(s) in an MCHCP plan within sixty (60) days of the court order.

5. If an active employee has elected coverage as a dependent of another MCHCP subscriber as allowed by these rules, and the subscriber dies before coverage as a dependent goes into effect, the active employee may elect coverage as a subscriber within thirty-one (31) days of the date of death.

(4) Effective Date Provision. In no circumstances can the effective date be before the eligibility date. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

#### (A) Employee and Dependent Effective Dates.

1. A new employee and his/her eligible dependent(s), or an employee rehired after his/her coverage terminates, and his/her eligible dependent(s) are eligible to participate in the plan on the first day of the month following the employee's eligibility date as determined by the employer.

2. Except at initial employment, an employee and his/her eligible dependents' effective date of coverage is the first of the month coinciding with, or after the eligibility date and applicable waiting period. The effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP except for newborns.

3. The effective date of coverage for a life event shall be as follows:

A. If enrollment by an employee is made before a wedding date, spouse's coverage becomes effective on the wedding date. The monthly premium is not prorated;

B. If enrollment by an employee is made within thirty-one (31) days of a wedding date, spouse's coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form and proof of eligibility;

C. If enrollment by a subscriber is made for a newborn of a member, the effective date for the newborn is the birth date. If enrollment is made by an employee due to the birth of a newborn of the employee, the effective date for the employee and newborn is the first of the month coinciding with or after enrollment is received;

D. If enrollment by an employee is made within thirty-one (31) days after the eligibility date, for an adoption, or placement of adopted children, coverage becomes effective on the eligibility date or the first day of the calendar month coinciding with or after the date the enrollment is received; or

E. If enrollment by an employee is made due to legal

guardianship of a dependent within thirty-one (31) days of guardianship effective date, the effective date for the dependent is the first day of the calendar month coinciding with or after the date the enrollment is received.

4. An employee and his/her eligible dependents who elect coverage and/or change coverage levels during open enrollment shall have an effective date of January 1 of the following year.

5. When a dependent of a subscriber first becomes eligible, coverage will become effective on the eligibility date or the first day of the month coinciding with or after the eligibility date if enrollment is made within thirty-one (31) days of the eligibility date.

6. A Qualified Medical Child Support Order is effective the first of the month coinciding with or after the form is received by the plan or date specified by the court.

(5) Proof of Eligibility.

(A) A public entity is required to obtain and keep on file proof of eligibility for dependents enrolled in an MCHCP medical, dental, and/or vision plan. Proof of eligibility documentation is required for all dependents.

1. Notification of the proof of eligibility policy will occur during the September 2012 public entity payroll representatives' informational meetings. Initial time frame for a public entity to obtain proof of eligibility documentation will occur September 1, 2012, through November 29, 2012.

2. Proof of eligibility must be obtained within thirty-one (31) days for a newly enrolled dependent and within ninety (90) days from date of birth for a newborn.

3. Coverage is provided for a newborn of a member from the moment of birth. The public entity or member must notify the plan of the birth verbally or in writing within thirty-one (31) days of the birth date. The plan will notify the public entity and member of the steps to continue coverage. The member is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not continue unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later.

4. MCHCP reserves the right to request proof of eligibility be provided at any time. If such proof is not received or is unacceptable as determined by MCHCP, coverage for the applicable dependent will be terminated or will not take effect.

5. Documentation is also required when a subscriber attempts to terminate a dependent's coverage in the case of divorce or death.

6. Acceptable forms of proof of eligibility are included in the following chart:

<b>Circumstance</b>	<b>Documentation</b>
Birth of dependent(s)	Government-issued birth certificate or other government-issued or legally-certified proof of eligibility listing subscriber as parent and newborn's full name and birth date
Addition of step-child(ren)	Marriage license to biological or legal parent/guardian of child(ren); and government-issued birth certificate or other government-issued or legally-certified proof of eligibility for child(ren) that names the subscriber's spouse as a parent or guardian and child's full name and birth date
Addition of foster child(ren)	Placement papers in subscriber's care
Adoption of dependent(s)	Adoption papers; Placement papers; or Filed petition for adoption; and Lists subscriber as adoptive parent
Legal guardianship of dependent(s)	Court-documented guardianship papers listing member as guardian (Power of Attorney is not acceptable)
Newborn of covered dependent	Government-issued birth certificate or legally-certified proof of eligibility for newborn listing covered dependent as parent with newborn's full name and birth date
Marriage	Marriage license or certificate recognized by Missouri law
Divorce	Final divorce decree; or Notarized letter from spouse stating s/he is agreeable to termination of coverage pending divorce or legal separation
Death	Death certificate
Loss of MO HealthNet or Medicaid	Letter from MO HealthNet or Medicaid stating who is covered and the date coverage terminates
MO HealthNet Premium Assistance	Letter from MO HealthNet or Medicaid stating member is eligible for the premium assistance program
Qualified Medical Child Support Order	Qualified medical child support order
Prior Group Coverage	Letter from previous insurance carrier or former employer stating date coverage terminated, reason for coverage termination, and list of dependents covered

7. Annually, MCHCP will require a signed attestation form verifying receipt of proof of eligibility from the public entity with enrolled dependents. A blank attestation form will be delivered to the public entity prior to open enrollment. Instructions to complete the form, filing requirements, and deadlines will accompany the attestation form.

(B) The employee is required to notify MCHCP on the appropriate form of the dependent's name, date of birth, eligibility date, and Social Security number.

(C) Permanently disabled children will continue to be eligible beyond age twenty-six (26) during the continuance of a permanent

disability, provided the following documentation is submitted to the public entity prior to the dependent's twenty-sixth birthday:

1. The Supplemental Security Income (SSI) Notice of Award from the Social Security Administration (SSA) verifying the dependent is entitled to and receiving disability benefits as of a specific date;

2. A letter from the dependent's physician describing the disability and verifying that the disability pre-dates the SSA determination; and

3. A current benefit verification letter from the SSA confirming the dependent is still considered disabled by SSA.

(D) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. Claims will not be processed until the required information is provided.

(6) Military Leave.

(A) Military Leave for an Employee who is not Retired.

1. For absences of thirty (30) days or less, coverage continues as if the employee has not been absent.

2. For absences of thirty-one (31) days or more, coverage ends unless the employee elects to pay for COBRA coverage. The agency payroll representative notifies MCHCP of the effective date of military leave.

3. If the employee is utilizing annual and/or compensatory balances and staying on payroll, the dependent coverage is at the active employee monthly premium.

4. If the employee does not elect to continue COBRA coverage for his/her eligible dependent(s), coverage ends effective the last day of the month in which the leave begins.

5. The former employee must submit a form within thirty-one (31) days of the employee's return to work for the same level of coverage with the same plan to be reinstated. The former employee must submit a form and an official document indicating the separation date if s/he elects coverage after thirty-one (31) days of returning to work.

6. Coverage may be reinstated the first of the month in which the member returns to employment, the first of the month after return to employment, or the first of the month after the loss of military coverage.

(B) Military Leave for a Retired Member.

1. A retiree must terminate his/her coverage upon entry into the armed forces of any country by submitting a form and copy of his/her activation papers within thirty-one (31) days of his/her activation date.

2. Coverage will be terminated the last day of the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of his/her separation papers and form within thirty-one (31) days of the separation date.

3. Coverage will be reinstated as of the first of the month in which the employee returns from active duty, the first of the month after the employee returns, or the first of the month after the loss of military coverage.

4. If the retired member fails to reinstate coverage, s/he cannot enroll at a later date.

5. If the employee terminates his/her coverage, dependent coverage is also terminated.

(7) Termination.

(A) Termination of coverage shall occur on the last day of the calendar month coinciding with or after the happening of any of the following events, whichever shall occur first:

1. Failure to make any required contribution toward the cost of coverage;

2. Entry into the armed forces of any country as defined in section (6);

3. With respect to employees, termination of coverage shall occur upon termination of employment, except as expressly specified otherwise in this rule. Termination of employee's coverage shall terminate the coverage of dependents;

4. With respect to dependents, termination of coverage shall occur upon divorce or legal separation from the subscriber or when a child reaches age twenty-six (26). A subscriber must terminate coverage for his/her spouse and stepchild(ren) at the time his/her divorce is final.

A. The public entity shall notify MCHCP when any of subscriber's dependents cease to be a dependent as defined in this chapter;

5. Death of dependent-the dependent's coverage ends on the

date of death.

A. The public entity shall notify MCHCP of a dependent's death;

6. Termination due to a member's act, practice, or omission that constitutes fraud or the member makes an intentional misrepresentation of material fact;

7. Termination due to a member's threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP;

8. A rescission will apply only to non-payment of a premium, fraud, or intentional misrepresentation. MCHCP shall provide at least thirty (30) days written notice before it rescinds coverage;

9. Termination of coverage shall occur immediately upon discontinuance of the plan subject to the plan termination provision specified in 22 CSR 10-3.080(1); and

10. If a member receives covered services after the termination of coverage, MCHCP may recover the contracted charges for such covered services from the subscriber or the provider, plus its cost to recover such charges, including attorneys' fees.

(8) Voluntary Cancellation of Coverage.

(A) A subscriber may cancel medical coverage, which will be effective on the last day of the month in which the form is received by MCHCP, unless the subscriber notifies MCHCP on the first calendar day of the month; then cancellation of coverage is effective the last day of the previous month.

1. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, the subscriber may only cancel medical coverage if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

(B) A subscriber may retroactively cancel coverage on his/her spouse to be effective on the last day of the month in which a divorce is final. A copy of the divorce decree must accompany the change request.

(C) If a member receives covered services after the voluntary cancellation of coverage, MCHCP may recover the contracted charges for such covered services from the subscriber or the provider, plus its cost to recover such charges, including attorneys' fees.

(D) A subscriber may only cancel dental and/or vision coverage during the year for themselves or their dependents for one (1) of the following reasons:

1. Upon retirement; or

2. When beginning a leave of absence.

(9) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) Eligibility. In accordance with COBRA, eligible employees and their dependents may temporarily continue their coverage when coverage under the plan would otherwise end. Coverage is identical to the coverage provided under MCHCP to similarly situated employees and family members. If members cancel COBRA coverage, they cannot enroll at a later date.

1. Employees voluntarily or involuntarily terminating employment (for reasons other than gross misconduct) or receiving a reduction in the number of hours of employment may continue coverage for themselves and their covered dependent(s) for eighteen (18) months at their own expense.

2. If a subscriber marries, has a child, or adopts a child while on COBRA coverage, eligible dependents can be added to the subscriber's plan upon notification to MCHCP. The subscriber may also add eligible dependents during open enrollment.

3. Dependents may continue coverage for up to thirty-six (36) months at their own expense if the covered employee becomes eligible to Medicare.

4. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

5. A divorced spouse and dependents may continue coverage at their own expense for up to thirty-six (36) months.

6. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense.

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage, the member may continue coverage for up to twenty-nine (29) months.

8. An employee who is on military leave is eligible for continued coverage for medical and dental care for the lesser of: a) twenty-four (24) months beginning on the date the leave begins; or b) the day after the date the employee fails to apply for or return to their position of employment following leave.

9. If the eligible member has Medicare prior to becoming eligible for COBRA coverage, the member is entitled to coverage under both.

**(B) Premium Payments.**

1. Initial payment for continuation coverage must be received within forty-five (45) days of election of coverage.

2. After initial premium payment, MCHCP bills on the last working day of the month. There is a thirty-one (31) day grace period for payment of regularly scheduled monthly premiums.

3. Premiums for continued coverage will be one hundred two percent (102%) of the total premium for the applicable coverage level. Once coverage is terminated under the COBRA provision, it cannot be reinstated.

**(C) Required Notifications.**

1. The subscriber or applicable member must notify MCHCP of a divorce, legal separation, a child turning age twenty-six (26), or Medicare entitlement within sixty (60) days of the event date.

2. The human resource/payroll office of the subscriber must notify MCHCP of an employee's death, termination, or reduction of hours of employment.

**(D) Election Periods.**

1. When MCHCP is notified that a COBRA-qualifying event has occurred, MCHCP notifies eligible members of the right to choose continuation coverage.

2. Eligible members have sixty (60) days from the date of coverage loss or notification from MCHCP, whichever is later, to inform MCHCP that they want continuation coverage.

3. If eligible members do not choose continuation coverage within sixty (60) days of lost coverage or notification from MCHCP, coverage ends.

**(E) Continuation of coverage may be cut short for any of these reasons—**

1. The state of Missouri no longer provides group health coverage to any of its employees;

2. Premium for continuation coverage is not paid on time;

3. The covered employee or dependent becomes covered (after the date s/he elects COBRA coverage) under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition s/he may have;

4. The covered employee or dependent becomes entitled to Medicare after the date s/he elects COBRA coverage; or

5. The covered employee or dependent extends coverage for up to twenty-nine (29) months due to disability and there has been a final determination that the individual is no longer disabled.

**(F) MCHCP assumes coverage for existing COBRA members until their eligibility period expires or until the public entity terminates coverage with MCHCP, whichever occurs first.**

**(10) Missouri State Law COBRA Wrap-Around Provisions.**

**(A)** Missouri law provides that if a member loses group health insurance coverage because of a divorce, legal separation, or the death of a spouse, the member may continue coverage until age sixty-five (65) under two (2) conditions—

1. The member continues and maintains coverage under the thirty-six (36)-month provision of COBRA; and

2. The member is at least fifty-five (55) years old when COBRA benefits end. The qualified beneficiary must apply to continue cov-

erage through the wrap-around provisions and will have to pay the entire premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium.

**(B)** If continuation coverage is not chosen within the proper time frames listed below, continuation of coverage ends—

1. Within sixty (60) days of legal separation or the entry of a decree of dissolution of marriage or prior to the expiration of a thirty-six (36)-month COBRA period, the legally separated or divorced spouse who seeks such coverage shall give MCHCP written notice of the qualifying event, including his/her mailing address;

2. Within thirty (30) days of the death of an employee whose surviving spouse is eligible for continued coverage or prior to the expiration of a thirty-six (36) month COBRA period, the human resource/payroll representative shall give MCHCP written notice of the death and the mailing address of the surviving spouse; or

3. Within fourteen (14) days of receipt of the notice, MCHCP shall notify the legally separated, divorced, or surviving spouse that coverage may be continued. The notice shall include:

A. A form for election to continue the coverage;

B. The amount of premiums to be charged and the method and place of payment; and

C. Instructions for returning the elections form by mail within sixty (60) days after MCHCP mails the notice.

**(C)** Continuation of coverage terminates on the last day of the month prior to the month the subscriber turns age sixty-five (65). The right to continuation coverage shall also terminate upon the earliest of any of the following:

1. The state of Missouri no longer provides group health coverage to any of its employees;

2. Premium for continuation coverage is not paid on time;

3. The date on which the legally separated, divorced, or surviving spouse becomes insured under any other group health plan;

4. The date on which the legally separated, divorced, or surviving spouse remarries and becomes insured under another group health plan; or

5. The date on which the legally separated, divorced, or surviving spouse reaches age sixty-five (65).

**(11) Medicare.**

**(A)** If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

**(B)** MCHCP's prescription drug plan is evaluated by a third party to determine whether it is creditable and considered equal to or better than Medicare Part D. The member will receive notification of the outcome from MCHCP. If MCHCP's plan is considered creditable, the member does not need to enroll in Medicare Part D and will not be penalized if s/he signs up for Part D at a later date.

**(C)** If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the donut hole.

**(12) Communications to Members.**

**(A)** It is the member's responsibility to ensure that MCHCP has current contact information for the member and any dependent(s).

**(B)** A member must notify MCHCP of a change in his/her mailing or email address as soon as possible, but no later than thirty-one (31) days after the change.



(C) It is the responsibility of all members who elect to receive plan communication through email to ensure plan emails are not blocked as spam or junk mail by the member or by the member's service provider.

(D) Failure to update a mailing or email address may result in undeliverable mail/email of important informational material, delayed or denied claims, loss of coverage, loss of continuation rights, missed opportunities relating to covered benefits, and/or liability for claims paid in error.

(13) Deadlines. Unless specifically stated otherwise, MCHCP computes deadlines by counting day one as the first day after the qualifying event. If the last day falls on a weekend or state holiday, the plan administrator may receive required information on the first working day after the weekend or state holiday.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency rescission and rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rescission and rule covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-3.045 Plan Utilization Review Policy.** The Missouri Consolidated Health Care Plan is amending section (1).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011,*

*becomes effective January 1, 2012, and expires June 28, 2012.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Prior [a/Authorization of /s/Services—The claims administrator must authorize some services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. [Participants] Members who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition will not be covered.

1. The following medical services are subject to prior authorization:

A. Ambulance services for non-emergent/cy/t use whether air or ground;

B. Anesthesia and hospital charges for dental care for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;

[B./C. Applied behavior[a/] analysis for autism;

D. Auditory brainstem implant (ABI);

E. Bariatric procedures;

[C./F. Cardiac and pulmonary rehabilitation after thirty-six (36) visits within a twelve (12)-week period;

[D./G. Chiropractic services after twenty-six (26) visits annually;

[E./H. Cochlear implant device;

I. Chelation therapy;

[F./J. Dental care to reduce trauma and restorative services when the result of accidental injury;

[G./K. Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;

[H./L. Genetic testing or counseling;

[I./M. Home health care and palliative services;

[J./N. Hospice care;

[K./O. Hospital inpatient services except for observation stays;

[L./P. Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

[M./Q. Nutritional counseling after three (3) sessions annually;

[N./R. Orthotics over one thousand dollars (\$1,000);

[O. Oxygen provided on an outpatient basis;]

[P./S. Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;

T. Procedures with codes ending in "T";

[Q./U. Prostheses over one thousand dollars (\$1,000);

[R./V. Skilled nursing facility;

[S./W. Surgery (outpatient)—The following outpatient surgical procedures: cornea transplant, potential cosmetic surgery, sleep apnea surgery, implantable stimulators, stimulators for bone growth, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); [surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth; reduction of fractures and dislocations of the jaw; excision of exostosis of jaws and hard palate; external incisions and drainage of cellulitis; incision of accessory sinuses, salivary glands, or ducts; or frenectomy];] and

[7./X. Transplants including requests related to covered travel and lodging.

2. The following pharmacy services are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications[. *Drugs that treat chronic, complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis. The specialty medication requires frequent dosage adjustments, clinical monitoring, and special handling and are often unavailable at retail pharmacies. The specialty medication must be filled through the claims administrator's home delivery pharmacy provider*];

C. Medications that may be prescribed for several conditions, including some [where] for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. The cost of the medication exceeds nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents (\$1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications.

3. Prior authorization time frames.

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen (15)-calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least forty-five (45) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

(B) Concurrent Review—The claims administrator will monitor the medical necessity of the inpatient admission to certify the necessity of the continued stay in the hospital. [Participants] Members who have another primary carrier, including Medicare, are not subject to this provision; and

(C) Retrospective Review—Reviews conducted after services have been provided to a patient. The retrospective review **does not** include/s/ **the review of a claim that is limited to** an evaluation of reimbursement levels, accuracy, and adequacy of documentation or coding, or settling of payment.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1)–(4); adding section (5); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the PPO 1000 Plan benefit provisions and covered charges of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) Deductible amount—Network: per individual each calendar year, one thousand dollars (\$1,000); family [limit] each calendar year, three thousand dollars (\$3,000). Non-network: per individual each calendar year, two thousand dollars (\$2,000); family [limit] each calendar year, six thousand dollars (\$6,000).

(C) During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and coinsurance. [The newborn will not be subject to a separate deductible and coinsurance.] The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital. **If the mother is not a Missouri Consolidated Health Care Plan member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.**

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims[—] are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims[—] are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(D) Claims shall be paid at ninety percent (90%) if required covered services are not available through a network provider within one hundred (100) miles of the member's home. The [participant] member must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is for three (3) months. After three (3) months, the [participant] member must contact the claims administrator to reassess network availability.

**(E) Preventive care—network claims are paid at one hundred percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible.**

(3) Copayments—set charges for the following *[types of claims so] services apply* as long as network providers are utilized **unless otherwise specified. Copayments do not apply to the deductible or out-of-pocket maximum.**

(A) Office visit—Network: primary care—twenty dollars (\$20), specialist—thirty dollars (\$30); Non-network: seventy percent (70%) coinsurance after deductible.

1. Vision office visit or refraction—thirty dollars (\$30).

2. Hearing test—performed by a primary care physician: twenty dollars (\$20); performed by a specialist: thirty dollars (\$30).

(B) Maternity—Network: primary care—twenty dollars (\$20) for initial visit, specialist—thirty dollars (\$30) for initial visit; **lab-covered at one hundred percent (100%); other diagnostic tests—ninety percent (90%) coinsurance after deductible; Non-network: all services paid at seventy percent (70%) coinsurance after deductible.**

*[(C)] Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: seventy percent (70%) coinsurance after deductible.]*

*[(D)](C) Emergency room—Network: one hundred dollar (\$100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar (\$100) copayment (waived if admitted as inpatient).*

*[(E)](D) Urgent care—Network: fifty dollar (\$50) copayment; Non-network: fifty dollar (\$50) copayment.*

**(E) Bariatric surgery—five hundred dollar (\$500) copayment and ten percent (10%) coinsurance after deductible is met.**

(4) Out-of-pocket maximum—the maximum amount payable by the *[participant] member* before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

**(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.**

**(B) The family out-of-pocket maximum is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member out-of-pocket maximums may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.**

*[(A)](C) Network out-of-pocket maximum for individual—four thousand five hundred dollars (\$4,500).*

*[(B)](D) Network out-of-pocket maximum for family—thirteen thousand five hundred dollars (\$13,500).*

*[(C)](E) Non-network out-of-pocket maximum for individual—ten thousand dollars (\$10,000).*

*[(D)](F) Non-network out-of-pocket maximum for family—thirty thousand dollars (\$30,000).*

*[(E)](G) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the *[U]sual, [C]ustomary, and [R]easonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.**

**(5) Usual, customary, and reasonable fee allowed—non-network medical claims are processed at the eighty-fifth percentile of usual, customary, and reasonable fees as determined by the vendor.**

*[(5)](6) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1)–(4); adding section (5); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the PPO 2000 Plan benefit provisions and covered charges of the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) Deductible amount—Network: per individual each calendar year, two thousand dollars (\$2,000); family *[limit]* each calendar year, six thousand dollars (\$6,000). Non-network: per individual each calendar year, four thousand dollars (\$4,000); family *[limit]* each calendar year, twelve thousand dollars (\$12,000).

(C) During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and coinsurance. *[The newborn will not be subject to a separate deductible and coinsurance.]* The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital. **If the mother is not a Missouri Consolidated Health Care Plan member, the newborn's claims**

will be subject to deductible and coinsurance during the hospital admission.

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(D) Claims shall be paid at eighty percent (80%) if required covered services are not available through a network provider within one hundred (100) miles of the member's home. The *[participant]* member must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is for three (3) months. After three (3) months, the *[participant]* member must contact the claims administrator to reassess network availability.

(E) Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: sixty percent (60%) coinsurance after deductible.

(3) Copayments—set charges for the following *[types of claims so]* services apply as long as network providers are utilized. Copayments do not apply to the deductible or out-of-pocket maximum.

(A) Office visit—Network: primary care—twenty-five dollars (\$25), specialist—thirty-five dollars (\$35); Non-network: sixty percent (60%) coinsurance after deductible.

1. Vision office visit or refraction—thirty-five dollars (\$35).

2. Hearing test primary care—twenty-five dollars (\$25); specialist: thirty-five dollars (\$35).

(B) Maternity—Network: primary care—twenty-five dollars (\$25) for initial visit, specialist—thirty-five dollars (\$35) for initial visit; lab—covered at one hundred percent (100%); other diagnostic tests—eighty percent (80%) coinsurance after deductible; Non-network: all services paid at sixty percent (60%) coinsurance after deductible.

*[(C)]* Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: sixty percent (60%) coinsurance after deductible.]

*[(D)]*(C) Emergency room—Network: one hundred dollar (\$100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar (\$100) copayment (waived if admitted as inpatient).

*[(E)]*(D) Urgent care—Network: fifty dollar (\$50) copayment; Non-network: fifty dollar (\$50) copayment.

(E) Bariatric surgery—five hundred dollar (\$500) copayment and twenty percent (20%) coinsurance after deductible is met.

(4) Out-of-pocket maximum—the maximum amount payable by the *[participant]* member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) The family out-of-pocket maximum is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member out-of-pocket maximums may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

*[(A)]*(C) Network out-of-pocket maximum for individual—six thousand dollars (\$6,000).

*[(B)]*(D) Network out-of-pocket maximum for family—eighteen thousand dollars (\$18,000).

*[(C)]*(E) Non-network out-of-pocket maximum for individual—twelve thousand dollars (\$12,000).

*[(D)]*(F) Non-network out-of-pocket maximum for family—thirty-six thousand dollars (\$36,000).

*[(E)]*(G) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copay-

ments; claims for services paid at one hundred percent (100%); charges above the *[U]*usual, *[C]*customary, and *[R]*reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(5) Usual, customary, and reasonable fee allowed—non-network medical claims are processed at the eighty-fifth percentile of usual, customary, and reasonable fees as determined by the vendor.

*[(5)]*(6) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

### EMERGENCY RESCISSION

**22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges.** This rule established the policy of the board of trustees in regard to the medical plan benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded and readopted to include detailed language to clarify medical plan benefit provisions and covered charges.*

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rescission is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be filed as an emergency rescission in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rescission, which covers the same material, is published in this issue of the Missouri Register. This emergency rescission complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure*

*fairness to all interested persons and parties under the circumstances. This emergency rescission was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Emergency rescission filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rescission covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY RULE**

**22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the medical plan benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan.*

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.*

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the Missouri Register. This emergency rule complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) Benefit Provisions Applicable to the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and High Deductible Health Plan (HDHP).

Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(2) Covered Charges Applicable to the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP.

(A) Covered charges are only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a non-covered service. This includes covered services:

1. Prescribed by an appropriate health care provider for the therapeutic treatment of injury or sickness;
2. To the extent they do not exceed any limitation or exclusion; and
3. For not more than the usual, customary, and reasonable charge, as determined by the claims administrator for the services provided, will be considered covered charges.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, customary, and reasonable, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and
2. The usual, customary, and reasonable charges in the area in which services and/or supplies are provided.

(C) A physician visit to seek a second opinion is a covered service.

(D) Services in a Country Outside of the United States. Emergency room and urgent care medical services are covered at the network benefit. All other non-emergency services are covered at the non-network benefit.

(E) Medical plan benefits, limitations, and exclusions effective January 1, 2012, are incorporated by reference into this rule and are available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, or online at [www.mchcp.org](http://www.mchcp.org). This rule does not include any later amendments or additions.

(F) Plan benefits for the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP are as follows:

1. Allergy testing and immunotherapy. Allergy testing and allergy immunotherapy is covered for members with clinically significant allergic symptoms. No coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning;

2. Ambulance service. Ambulance transport services involve the use of specially designed and equipped vehicles to transport ill or injured individuals. Ambulance transportation by ground to the nearest appropriate facility is covered when medically necessary and other means of transportation would be contraindicated. This can include emergent and non-emergent, yet medically necessary situations. Ambulance transportation by air to the nearest appropriate facility is covered when medically necessary and only if the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Use of air ambulance or medical helicopter service from any country returning to the U.S. is excluded;

3. Applied behavior analysis for autism. For children younger than age nineteen (19), the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior are covered with a forty thousand dollar (\$40,000) annual limit. The annual limit may be exceeded, upon prior authorization by the medical plan, if services beyond the annual limit are medically necessary;

4. Bariatric surgery. Open or laparoscopic Roux-en-Y gastric bypass (RYGB), open or laparoscopic sleeve gastrectomy (SG), open or laparoscopic biliopancreatic diversion (BPD) with or without duodenal switch (DS), or laparoscopic adjustable silicone gastric banding (LASGB) are covered when specific health criteria are met;

5. Birth control devices and injections. Birth control is any method used to prevent pregnancy. Food and Drug Administration (FDA)-approved birth control devices and injections are covered when administered in a physician's office;

6. Cancer trials. Coverage for routine patient care costs incurred as the result of a Phase II, III, or IV clinical trial that is approved by an appropriate entity and is undertaken for the purposes of the prevention, early detection, or treatment of cancer. Coverage includes routine patient care costs incurred for drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's condition. Coverage includes reasonable and medically-necessary services needed to administer the drug or use the device under evaluation in the clinical trial;

7. Cardiac rehabilitation. Coverage for an electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) as medically necessary when it is individually prescribed by a physician and a formal exercise stress test is completed following the event and prior to the initiation of the program. Up to thirty-six (36) visits are covered within a twelve (12)-week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

8. Chelation therapy. Chelation therapy agents covered for FDA-approved indication(s) and associated condition(s). Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit are explicitly excluded under MCHCP's benefit plan. Therefore, treatment of metal toxicity that occurs as a result of occupational exposure is not covered;

9. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered. Up to twenty-six (26) visits covered annually. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

10. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation is covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device.

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

11. Dental care/accidental injury. Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors, or cysts. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization. General anesthesia is covered when dental care is provided in a participating or non-participating hospital or surgical center;

12. Durable medical equipment (DME)/medically necessary disposable supplies. DME is covered when the equipment is ordered by a physician to treat an injury or sickness (illness). DME includes, but is not limited to, insulin pumps, oxygen, augmentative commu-

nication devices, and manual and powered mobility devices. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, colostomy and ureterostomy bags and prescription compression stockings, are covered. Prescription compression stockings are limited to two (2) pairs or four (4) individual stockings per plan year. Non-reusable disposable supplies, including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered. Repair and replacement of DME is covered when—

A. Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

B. Routine wear and tear of the equipment renders it non-functional and the member still requires the equipment; or

C. The physician provides documentation that the condition of the member changes or if growth-related;

13. Emergency room services. An emergency medical condition is defined as the manifestation of acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If admitted to hospital, may be required to transfer to network facility for maximum benefit;

14. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

15. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when associated with systemic conditions that are significant enough to result in severe circulatory insufficiency and/or areas of desensitization in the lower extremities and service is provided by a qualified health provider. Foot care is considered routine in nature and not medically necessary in the absence of systemic disease that has resulted in severe circulatory insufficiency and/or areas of desensitization in the lower extremities;

16. Genetic counseling. The National Society of Genetic Counselors defines genetic counseling as: "The process of helping people understand and adapt to the medical, psychological and familial implications of genetic contributions to disease." Pre-test and post-test genetic counseling with a physician or a licensed or certified genetic counselor covered as medically necessary for an individual recommended for covered heritable genetic testing;

17. Genetic testing. No coverage for testing based on family history alone. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

A. The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

B. The result of the test will directly impact the treatment being delivered to the member;

C. The testing method is considered scientifically valid for identification of a genetically linked heritable disease; and

D. After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

18. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

19. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars (\$200), and the lifetime maximum is three thousand two hundred dollars (\$3,200);

20. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. Covered once every

two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars (\$1,000).

B. Programmable: two thousand dollars (\$2,000).

C. Digital: two thousand five hundred dollars (\$2,500).

D. Bone Anchored Hearing Aid (BAHA): three thousand five hundred dollars (\$3,500);

21. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by physician;

22. Home health care. Skilled home health care is covered for members who are homebound because of illness or injury (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent, or of short duration, or to receive medical care); services must be performed by a registered nurse or licensed practical (vocational) nurse, licensed therapist, or a registered dietitian;

23. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care which is directed mostly toward palliative care and symptom management) and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week;

24. Hospital (includes inpatient, outpatient and surgical centers). The following benefits are covered:

A. Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

B. Intensive care unit room and board;

C. Surgery, therapies, and ancillary services—

(I) Cornea transplant-travel and lodging are not covered for cornea transplant;

(II) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(III) Sterilization for the purpose of birth control is covered;

(IV) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(V) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19); and

(VI) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

D. Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(I) Member must be ill in more than one area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(II) The member's mental health disorder must be treatable in an inpatient facility;

(III) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual (DSM)*. If

outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region; and

(IV) The attending physician must be a psychiatrist. If the admitting physician is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board eligible or board certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of mental health disorders;

E. Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multi-disciplinary services not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment;

F. Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and

G. Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one of the following:

(I) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(II) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(III) A state-licensed psychologist;

(IV) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(V) Licensed professional counselor;

25. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition;

26. Maternity coverage. Prenatal and postnatal care is covered. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two (2)-visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility;

27. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian), up to three (3) sessions annually with a registered dietitian with physician order. The maximum may be exceeded for an additional three (3) sessions, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating



habits have not been proven to be essential to the overall treatment program because they are not considered to be medically necessary. Conditions for which nutritional evaluation and counseling are not considered to be medically necessary include, but are not limited to, the following:

- A. Attention-deficit/hyperactivity disorder (ADHD);
- B. Chronic fatigue syndrome (CFS);
- C. Idiopathic environmental intolerance (IEI); or
- D. Asthma;

28. Nutritional therapy. Nutritional therapy is covered when it is the sole source of nutrition or a significant percentage of the daily caloric intake; is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder; is prescribed by a physician; is necessary to sustain life or health; and requires ongoing evaluation and management by a licensed healthcare provider.

29. Office visit. Member encounter with a health care or mental health care/chemical dependency provider in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan being provided, including non-specialty infusions and injections. Specialty injections NEUPOGEN® (Filgrastim) and Neulasta® (Pegfilgrastim) are covered under the medical plan when the treating physician deems it medically necessary to be administered in the physician's office rather than as a self-injectable;

30. Orthotics. Therapeutic shoes, inserts, and/or modifications to therapeutic shoes; thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis; helmets-covered when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living; and cranial orthosis for plagiocephaly, cervical orthosis, hip orthosis, knee orthosis, and ankle-foot/knee-ankle-foot orthoses (AFO) are covered;

31. Physical, speech, and occupational therapy and rehabilitation services (outpatient). Up to sixty (60) combined visits allowed per incident if showing significant improvement. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

#### 32. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Annual physical exams (well man, woman, and child) and routine lab and X-ray services ordered as part of the annual exam. One exam (1) per calendar year is covered. For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

#### F. Cancer screenings:

- (I) Mammograms—one exam per year, no age limit;
- (II) Pap smears—one per year, no age limit;
- (III) Prostate—one per year, no age limit; and
- (IV) Colorectal Screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive regardless of diagnosis. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Flu vaccination (influenza). The seasonal flu vaccine is covered under the preventive care benefit. When shot is obtained out-of-network, member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive up to twenty-five dollars (\$25). Multiple vaccinations covered if recommended by

the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.

(I) Standard or preservative-free injectable influenza vaccine is a medically necessary preventive service for members when influenza immunization is recommended by the member's doctor.

(II) Intradermal influenza vaccine is a medically necessary preventive service for members eighteen (18) to sixty-four (64) years of age when influenza immunization is recommended by the member's doctor.

(III) Intranasally administered influenza vaccine is a medically necessary alternative to injectable influenza vaccine for immunocompetent healthy persons two (2) to forty-nine (49) years of age when influenza immunization is recommended by the member's doctor;

33. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition or if growth-related;

34. Pulmonary rehabilitation. Up to thirty-six (36) visits within a twelve (12)-week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and postoperative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) and/or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake ( $\text{VO}_{2\text{max}}$ ) equal to or less than twenty milliliter per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted.

35. Skilled nursing facility. Benefits are limited to one hundred twenty (120) days per calendar year;

36. Stimulators (for bone growth). Implantable bone growth stimulators covered as an outpatient surgery, nonimplantable bone growth stimulator covered under durable medical equipment.

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)). Medically-necessary DME to accelerate healing of fresh fractures, fusions, or delayed unions.

B. Electrical stimulation: direct current electrical bone-growth stimulator medically necessary for delayed unions of fractures or failed arthrodesis, non-unions, failed fusions, and congenital pseudarthrosis and members who are at high risk for spinal fusion

failure;

37. Transplants. When neither experimental nor investigational and medically necessary: bone marrow, kidney, liver, heart, lung, pancreas, intestinal, or any combination are covered under the transplant benefits. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements. Travel, if approved, is limited to ten thousand dollars (\$10,000) maximum per transplant.

A. Network. Includes travel and lodging allowance for recipient and his/her immediate family travel companion (younger than nineteen (19), both parents) if transplant facility is more than one hundred (100) miles from residence.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to [www.gsa.gov](http://www.gsa.gov) for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Transplant benefits at a non-network facility. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals not covered. Non-network facility charges and payments for transplants are limited to the following maximum only:

(I) Allogenic bone marrow—one hundred forty three thousand dollars (\$143,000);

(II) Autologous bone marrow—one hundred twenty-one thousand dollars (\$121,000);

(III) Heart—one hundred twenty-eight thousand dollars (\$128,000);

(IV) Heart and lung—one hundred thirty-three thousand dollars (\$133,000);

(V) Lung—one hundred fifty-one thousand dollars (\$151,000);

(VI) Kidney—Fifty-four thousand dollars (\$54,000);

(VII) Kidney and Pancreas—ninety-seven thousand dollars (\$97,000); and

(VIII) Liver—one hundred fifty-three thousand dollars (\$153,000);

38. Urgent care. Services to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician's office but not severe enough to require treatment in a hospital emergency department; and

39. Vision. Routine exam (including refractions). One (1) per covered person per calendar year.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Emergency rescission and rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rescission and rule covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY AMENDMENT**

**22 CSR 10-3.075 Review and Appeals Procedure.** The Missouri Consolidated Health Care Plan is amending sections (1)–(5); adding section (1); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to review and appeals procedures for participation in, and coverage of services under, the Missouri Consolidated Health Care Plan.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

**(1) General Provision. The board of trustees has the right to suspend, revise, or remove eligibility and benefit requirements in the case of a disaster or emergency situation.**

**[(1)](2) Claims Submissions and Initial Benefit Determinations.**

(A) Members shall use the claims and administration procedures established by the vendor administering the particular service for which coverage, authorization, or payment is sought.

(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.

1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a decision whether a treatment, procedure, or medication is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days from the date the vendor receives the claim. The vendor may extend the time period up to an additional fifteen (15) days if, for reasons beyond the vendor's control, the decision cannot be made within the first fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be

submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor as soon as possible thereafter.

2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than thirty (30) days after the vendor receives the claim. If, because of reasons beyond the vendor's control, more time is needed to review the claim, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

3. Concurrent claims are claims related to an ongoing course of previously/-/ approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously/-/ approved course of treatment in sufficient time to allow the member or the member's provider to appeal and obtain a determination before the benefit is reduced or terminated.

(C) Claims incurred should be furnished to the vendor by the provider or the member as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the vendor before they are paid.

(D) If a member, or a provider, or authorized representative on behalf of a member, submits a request for coverage or a claim for services that is denied in whole or in part, the member will receive an initial denial notice within the time frames described in this rule that will include the following information:

1. The reasons for the denial;
2. Reference to the plan provision, regulation, statute, clinical criteria, or guideline on which the denial was based, with information as to how the member can obtain a copy of the provision, regulation, statute, clinical criteria, or guideline free of charge;
3. A description of any documentation or information that is necessary for the member to provide if documentation or information is missing and an explanation as to why the documentation or information is needed, if applicable; and
4. Information as to steps the member can take to submit an appeal of the denial.

#### //(2)/(3) General Appeal Provisions.

(A) All individuals seeking review or appeal of a decision of the plan, plan administrator, claims administrator, or any vendor shall follow the procedures applicable to the type of decision appealed as set forth in this rule.

(B) All appeals must be submitted in writing to the appropriate reviewer as established in this rule by the member, the individual seeking review, or his/her authorized representative.

(C) Unless specifically provided otherwise in this rule, all appeals to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of receiving the denial or notice which gave *[rights]* rise to the appeal.

#### //(3)/(4) Appeal Process for Medical and Pharmacy Determinations.

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a

claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply.

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage *[once]* after an individual has been covered under the plan.

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination.

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative.

4. External review. External review means a review of an adverse benefit determination (including a final internal adverse benefit determination) by the Missouri Department of Insurance, Financial Institutions and Professional Registration, Division of Consumer Affairs (DIFP) regarding covered medical *[and pharmacy]* benefits administered by *[plan vendors, UMR, Mercy Health Plans, or Express Scripts Inc.,]* **Coventry Health Care** in accordance with state law and regulations promulgated by DIFP *[and made applicable to the plan by agreement and between the plan and DIFP pursuant to Technical Guidance from the U.S. Department of Health and Human Services dated September 23, 2010]*. **The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by UMR and Express Scripts Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time).**

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law.

6. Final external review decision. A final external review decision means a determination rendered under the *[DIFP]* external review process at the conclusion of an external review.

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect;

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

C. The termination or discontinuance of coverage is effective

retroactively at the request of the member in accordance with applicable provisions of this chapter regarding voluntary cancellation of coverage.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review *[by DIFP]* except as specifically provided in 22 CSR 10-3.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal

decision should be overturned. Second level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First level appeals must be submitted in writing to—

UMR Claims Appeal Unit  
PO Box 30546  
Salt Lake City, UT 84130-0546

(b) Second level appeals must be sent in writing to—

UMR Claims Appeal Unit  
PO Box 8086  
Wausau, WI 54402-8086

(c) Expedited appeals must be communicated by calling UMR telephone 1-866-868-7758 or by submitting a written fax to 1-866-912-8464, Attention: Appeals Unit.

(VI) For members with medical coverage through *[Mercy Health Plans]* Coventry Health Care—

(a) First and second level appeals must be submitted in writing to—

*[Mercy Health Plans  
Attn: Corporate Appeals  
14528 S. Outer 40 Road, Suite 300  
Chesterfield, MO 63017]  
Coventry Health Care  
Attn: Appeals Department  
550 Maryville Centre, Ste. 300  
St. Louis, MO 63141*

(b) Expedited appeals must be communicated by calling *[Mercy Health Plans]* Coventry Health Care telephone *[1-800-830-1918, ext. 2394]* 1-314-214-2394 or by submitting a written fax to 1-314-214-3233, Attention: Corporate Appeals.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member claimant attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the claimant believes the claim should be paid, and any other written documentation to support the claimant's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts  
*[Clinical Appeals—MH3  
6625 West 78th Street, BL0390]  
Attn: Pharmacy Appeals—MH3  
Mail Route 0390  
6625 W. 78th St.  
Bloomington, MN 55439  
or by fax to 1-877-852-4070*

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30)

days for pre-service claims from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

**(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.**

**(II) The claimant can submit an external review request in writing to—**

**Office of Consumer Information and Oversight  
Department of Health and Human Services  
PO Box 791  
Washington DC 20044  
or by fax to 1-202-606-0036  
or by email to [disputedclaim@opm.gov](mailto:disputedclaim@opm.gov)**

**(III) The claimant may call the toll-free number 1-877-549-8152 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.**

**(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.**

**(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.**

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

**[(4)](5) Except as otherwise expressly provided in this rule, appeals of adverse determinations made by MCHCP may be appealed to the board by fax or letter to the following address:**

**Attn: Appeal  
Board of Trustees  
Missouri Consolidated Health Care Plan  
PO Box 104355  
Jefferson City, MO 65110**

**[(5)](6) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines.**

**(A) Newborns—If a member currently has coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within three (3) months of the child's date of birth.**

**(B) Agency error—MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office, *[the]* MCHCP, or plan offered by MCHCP that was no fault of the member.**

**(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days**

**of the beginning of the new plan year. Plan changes are effective February 1. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

**(D) Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).**

**(E) Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.**

**(F) Termination dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, termination may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

**(G) Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for the public entity (county or state) to provide subscriber with requested documentation.**

**(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

**(I) Loss of coverage notice—MCHCP may approve late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.**

**(J) *[Wellness Program]* Lifestyle Ladder participation—MCHCP may deny all appeals regarding continuation of participation in the *[Wellness]* Lifestyle Ladder Program due to failure of member's participation.**

**(K) Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.**

**(L) Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.**

**(M) New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

## **Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN**

### **Division 10—Health Care Plan Chapter 3—Public Entity Membership**

#### **EMERGENCY AMENDMENT**

**22 CSR 10-3.090 Pharmacy Benefit Summary.** The Missouri Consolidated Health Care Plan is deleting sections (2), (4), and (8);

amending the purpose, sections (1), (5), and (7); adding sections (6)–(8); and renumbering as necessary.

**PURPOSE:** *This amendment changes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP with HSA of the Missouri Consolidated Health Care Plan.*

**PURPOSE:** *This rule establishes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for the PPO 600 Plan, PPO 1000 Plan, [and] PPO 2000 Plan, and HDHP with HSA of the Missouri Consolidated Health Care Plan.*

**EMERGENCY STATEMENT:** *This emergency amendment must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency amendment is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment in order to maintain the integrity of the current health care plan. This emergency amendment must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the Missouri Register. This emergency amendment complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) The pharmacy benefit provides coverage for prescription drugs. [listed on the formulary, as described in the following:] Vitamins and nutrients coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a physician.

(A) [Medications] PPO 600, PPO 1000, and PPO 2000 Prescription Drug Coverage.

1. Retail—Network:

A. Generic: Eight-dollar (\$8) copayment for up to a thirty (30)-day supply for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%);

B. Brand: Thirty-five-dollar (\$35) copayment for up to a thirty (30)-day supply for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%);

C. Non-formulary: One hundred dollar (\$100) copayment for up to a thirty (30)-day supply for a drug not on the formulary;

[C./D. [Mail order] Home delivery program—

(1) [Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for a twenty-dollar (\$20) copayment for a generic drug on the formulary or a eighty-seven-dollar-and-

fifty-cent (\$87.50) copayment for a brand drug on the formulary.] Maintenance prescriptions may be filled through the home delivery program. Some medications may not apply for the program because they require prior authorization or quantity level limits.

(a) Generic: Twenty dollar (\$20) copayment for up to a ninety (90)-day supply for a generic drug on the formulary.

(b) Brand: Eighty-seven dollars and fifty cents (\$87.50) copayment for up to a ninety (90)-day supply for a brand drug on the formulary.

(c) Non-formulary: Two hundred fifty dollar (\$250) copayment for up to a ninety (90)-day supply for a drug not on the formulary; and

(II) Specialty drugs covered only through network [mail order] home delivery for up to thirty (30) days. [Copayments—] The first specialty prescription order may be filled through a retail pharmacy.

(a) Generic: [e/E]ight dollars (\$8) for generic drug on the formulary list[; and].

(b) Brand: [t/T]hirty-five dollars (\$35) for brand drug on the formulary.

(c) Non-formulary: One hundred dollar (\$100) copayment for a drug not on the formulary;

E. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

F. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment;

G. If the physician allows for generic substitution and the member chooses a brand name drug, the member is responsible for the generic copayment and the cost difference between the brand name and generic drug; and

H. Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary through the pharmacy benefit.

2. [Non-network pharmacies] Retail—Non-network:[—] If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. [S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable copayment or coinsurance. All such claims must be filed within twelve (12) months of the incurred expense.] The pharmacy vendor will reimburse the cost of the drug based on the network discounted amount, less the applicable copayment.

A. Generic: Eight dollar (\$8) copayment for up to a thirty (30)-day supply for a generic drug on the formulary.

B. Brand: Thirty-five dollar (\$35) copayment for up to a thirty (30)-day supply for a brand drug on the formulary.

C. Non-formulary: One hundred dollar (\$100) copayment for up to a thirty (30)-day supply for a drug not on the formulary.

[3. Retail prescription drugs—Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.]

(B) High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Prescription Drug Coverage.

1. Retail—Network:

A. Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary; tobacco cessation prescriptions covered at 100%;

B. Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary; tobacco cessation prescriptions covered at 100%;

C. Non-formulary: Thirty percent (30%) coinsurance

after deductible for a drug not on the formulary;

**D. Home delivery program.**

(I) Maintenance prescriptions may be filled through the home delivery program. Some medications may not apply for the program because they require prior authorization or quantity level limits.

(a) Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

(c) Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary.

(II) Specialty drugs covered only through network home delivery for up to thirty (30) days.

(a) Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

(c) Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary; and

**E. Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary through the pharmacy benefit.**

**2. Retail—Non-network:** If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. The pharmacy vendor will reimburse the cost of the drug based on the network discounted amount, less the applicable coinsurance.

**A. Generic: Forty percent (40%) coinsurance after deductible for up to a thirty (30)-day supply for a generic drug on the formulary.**

**B. Brand: Forty percent (40%) coinsurance after deductible for up to a thirty (30)-day supply for a brand drug on the formulary.**

**C. Non-formulary: Fifty percent (50%) coinsurance after deductible for up to a thirty (30)-day supply for a drug not on the formulary.**

*[(2) If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment.]*

*[(3)](2) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first step drug, the physician may request a prior authorization from the pharmacy plan administrator. If the prior authorization is approved, the member is responsible for the applicable copayment which may be higher than the first step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.*

**(A) First Step—**

1. Uses primarily generic drugs;
2. Lowest applicable copayment is charged; and
3. First step drugs must be used before the plan will authorize payment for second step drugs.

**(B) Second Step—**

1. This step applies if the member's treatment plan requires a different medication after attempting the first step medication;
2. Uses primarily brand-name drugs; and

3. Typically, a higher copayment amount is applicable.

*[(4) Prior Authorization—Certain medications are subject to prior authorization. Network pharmacies will notify the member if prior authorization is required. The member or the pharmacy must contact the pharmacy plan administrator before payment will be approved.]*

*[(5)](3) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan administrator. In order to file a claim, members must—*

*(A) Complete the claim form; [and]*

*(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions, except diabetic supplies. If attaching a receipt or label, the receipt or label shall include:*

1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;
7. Quantity; and
8. Days' supply./; and

*(C) Members must file a claim to receive reimbursement of the cost of a prescription filled at a non-network pharmacy. Non-network pharmacy claims are allowed at the network discounted price as determined by the vendor minus any applicable copayment. Members are responsible for any charge over the network discounted price and the applicable copayment.*

*[(6)](4) Formulary—The formulary is updated on a semi-annual basis, or when—*

*(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; or*

*(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; or*

*(C) A drug is determined to have a safety issue.*

*[(7)](5) [Limitation—Prescription drugs not listed on the formulary are not a covered benefit except for prescription drugs that have been grandfathered for members who have taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011. If the participant purchased a brand-name drug that is grandfathered when there is a Food and Drug Administration (FDA)-approved generic drug, the participant shall pay the generic copayment plus the difference in the brand and generic cost of the drug.]*

**Grandfathered Specialty Drugs—Prescription drugs grandfathered for members in 2011 because they had taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011, will continue to be covered at a thirty-five dollar (\$35) brand copayment level if enrolled in a PPO plan or at twenty percent (20%) coinsurance if enrolled in the HDHP plan. Grandfathered drugs include:**

**(A) Alzheimer's disease drugs;**

**(B) Antidepressants, including selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and norepinephrine reuptake inhibitors (SNRIs);**

**(C) Anti-epileptics;**

**(D) Attention-deficit hyperactivity disorder (ADHD);**

**[(D)](E) Biologics for inflammatory conditions;**

**[(E)](F) Cancer drugs;**

**[(F)](G) Hemophilia drugs (FVIII and IX concentrates);**

**[(G)](H) Hepatitis drugs;**

**[(H)](I) Immunosuppressants (transplant anti-rejection agents);**



[(I)](J) Insulin (basal);  
[(J)](K) Low molecular weight heparins;  
[(K)](L) Multiple sclerosis injectable drugs;  
[(L)](M) Novel psychotropics (oral products and long-active injectables);  
[(M)](N) Phosphate binders;  
[(N)](O) Pulmonary hypertension drugs; and  
[(O)](P) Somatostatin analogs.

[(8) Under the High Deductible Health Plan (HDHP), pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.]

**(6) Medicare Part B Prescription Drugs—**For covered Medicare Part B prescriptions, Medicare and MCHCP will coordinate to provide up to one hundred percent (100%) coverage for the drugs. To receive Medicare Part B prescriptions without a copayment or coinsurance, the subscriber must submit prescriptions and refills to an MCHCP vendor-contracted participating Medicare Part B retail pharmacy or use the MCHCP vendor-contracted home delivery service. Medicare Part B prescriptions include, but are not limited to, the following:

- (A) Diabetes testing and maintenance supplies;
- (B) Respiratory agents;
- (C) Immunosuppressants; and
- (D) Oral anti-cancer medications.

**(7) Quantity Level Limits—**Quantities of some medications may be limited based on recommendations by the Food and Drug Administration and medical literature. Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.

**(8) Guidelines for Drug Use—**If MCHCP suspects drug misuse, abuse, or fraud, MCHCP reserves the right to pay only for those medications prescribed by an assigned physician approved by MCHCP.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**EMERGENCY RULE**

**22 CSR 10-3.100 Fully-Insured Medical Plan Provisions**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the Fully-Insured Plan Provisions of the Missouri Consolidated Health Care Plan relative to public entities and public entity members.*

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2012, in accordance with the new plan year. Therefore, this emergency rule is necessary to protect members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage inter-*

*rupted due to confusion regarding eligibility or availability of benefits and allows members to take advantage of opportunities for reduced premiums for more affordable options without which they may forgo coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be filed as an emergency rule in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2012, to fulfill the compelling governmental interest of offering continuous health insurance to officers, state and public entity employees, retirees, and their families. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed rule, which covers the same material, is published in this issue of the Missouri Register. This emergency rule complies with the protections extended by the Missouri and United States Constitutions and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency rule was filed November 1, 2011, becomes effective January 1, 2012, and expires June 28, 2012.*

(1) A fully-insured medical plan is subject to applicable Department of Insurance, Financial Institutions and Professional Registration (DIFP) statutes and regulations. Members enrolled in a fully-insured medical plan will have rights and responsibilities as provided in those applicable statutes and regulations. If and to the extent there is a conflict between the plan and DIFP statutes and regulations, DIFP statutes and regulations shall prevail. Governing DIFP statutes and regulations include but are not limited to appeals, timelines, and payments.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. A proposed rule covering this same material is published in this issue of the Missouri Register.*

**U**nder this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

**E**ntirely new rules are printed without any special symbolology under the heading of the proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

**A**n important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

**I**f an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register*. If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

**A**n agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety (90)-day-count necessary for the filing of the order of rulemaking.

**I**f an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:

**Boldface text indicates new matter.**

*[Bracketed text indicates matter being deleted.]*

**Title 10—DEPARTMENT OF NATURAL RESOURCES**  
**Division 10—Air Conservation Commission**  
**Chapter 2—Air Quality Standards and Air Pollution**  
**Control Rules Specific to the Kansas City Metropolitan**  
**Area**

**PROPOSED AMENDMENT**

**10 CSR 10-2.385 Control of Heavy Duty Diesel Vehicle Idling Emissions.** The commission proposes to amend the rule purpose, amend subsection (1)(B), add new subsection (1)(C), and renumber original subsection (1)(C) as (1)(D). If the commission adopts this rule action, it will be the department's intention to submit this rule amendment to the U.S. Environmental Protection Agency to replace the current rule that is in the Missouri State Implementation Plan. The evidence supporting the need for this proposed rulemaking is available for viewing at the Missouri Department of Natural

Resources' Air Pollution Control Program at the address listed in the Notice of Public Hearing at the end of this rule. More information concerning this rulemaking can be found at the Missouri Department of Natural Resources' Environmental Regulatory Agenda website, [www.dnr.mo.gov/regs/index.html](http://www.dnr.mo.gov/regs/index.html).

*PURPOSE: The purpose of this rule is to implement restrictions on the idling of heavy duty diesel vehicles in the Kansas City Ozone Maintenance Area. The purpose of this amendment is to clarify a discrepancy between the affected parties in the Applicability section and the stated requirements in the General Provisions section. The evidence supporting the need for this proposed rulemaking, per section 536.016, RSMo, is an email dated November 4, 2010, from the U.S. Environmental Protection Agency, Region 7 and a rule comment form dated November 24, 2010, from Missouri Department of Natural Resources staff.*

*PURPOSE: The purpose of this rule[making] is to implement restrictions on the idling of heavy duty diesel vehicles in the Kansas City Ozone Maintenance Area. The evidence supporting the need for this [proposed] rule[making], per section 536.016, RSMo, is the federally approved 2007 Kansas City Maintenance Plan for the Control of Ozone.*

**(1) Applicability.**

(B) This regulation applies to owners or operators of commercial, public, and institutional heavy duty diesel vehicles that are designed to operate on public streets and highways, whether or not the vehicles are operated on public roadways.

**(C) This regulation applies to owners and operators of load/unload locations where commercial, public, and institutional heavy duty diesel vehicles load or unload passengers.**

*[(C)](D)* Passenger vehicles as defined in subsection (2)(H) of this rule are exempt from this rule.

*AUTHORITY: section 643.050, RSMo 2000. Original rule filed July 11, 2008, effective Feb. 28, 2009. Amended: Filed Oct. 28, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing on this proposed amendment will begin at 9:00 a.m., February 2, 2012. The public hearing will be held at the Elm Street Conference Center, 1730 East Elm Street, Lower Level, Bennett Springs Conference Room, Jefferson City, Missouri. Opportunity to be heard at the hearing shall be afforded any interested person. Interested persons, whether or not heard, may submit a written or email statement of their views until 5:00 p.m., February 9, 2012. Written comments shall be sent to Chief, Air Quality Planning Section, Missouri Department of Natural Resources' Air Pollution Control Program, PO Box 176, Jefferson City, MO 65102-0176. Email comments shall be sent to [apcprulespn@dnr.mo.gov](mailto:apcprulespn@dnr.mo.gov).*

**Title 10—DEPARTMENT OF NATURAL RESOURCES**  
**Division 10—Air Conservation Commission**  
**Chapter 5—Air Quality Standards and Air Pollution**  
**Control Rules Specific to the St. Louis Metropolitan**  
**Area**

**PROPOSED AMENDMENT**

**10 CSR 10-5.385 Control of Heavy Duty Diesel Vehicle Idling Emissions.** The commission proposes to amend the rule purpose; amend subsections (1)(B), (2)(B), and (3)(C); add new subsection (1)(C); and renumber original subsection (1)(C) as (1)(D). If the commission adopts this rule action, it will be the department's intention to submit this rule amendment to the U.S. Environmental Protection Agency to replace the current rule that is in the Missouri State Implementation Plan. The evidence supporting the need for this proposed rulemaking is available for viewing at the Missouri Department of Natural Resources' Air Pollution Control Program at the address listed in the Notice of Public Hearing at the end of this rule. More information concerning this rulemaking can be found at the Missouri Department of Natural Resources' Environmental Regulatory Agenda website, [www.dnr.mo.gov/reg/index.html](http://www.dnr.mo.gov/reg/index.html).

*PURPOSE: The purpose of this rule is to implement restrictions on the idling of heavy duty diesel vehicles in the St. Louis Ozone Nonattainment Area. The purpose of this amendment is to clarify a discrepancy between the affected parties in the Applicability section and the stated requirements in the General Provisions section. The evidence supporting the need for this proposed rulemaking, per section 536.016, RSMo, is an email dated November 4, 2010, from the U.S. Environmental Protection Agency, Region 7 and a rule comment form dated November 24, 2010, from Missouri Department of Natural Resources staff.*

*PURPOSE: The purpose of this rule[making] is to implement restrictions on the idling of heavy duty diesel vehicles in the St. Louis Ozone Nonattainment Area. The evidence supporting the need for this [proposed] rule[making], per section 536.016, RSMo, is the federally approved 2007 Revision of the State Implementation Plan for the St. Louis Eight (8)-Hour Ozone Nonattainment Area.*

(1) Applicability.

(B) This regulation applies to owners or operators of commercial, public, and institutional heavy duty diesel vehicles that are designed to operate on public streets and highways, whether or not the vehicles are operated on public roadways.

(C) **This regulation applies to owners or operators of load/unload locations where commercial, public, and institutional heavy duty diesel vehicles load or unload passengers.**

[(C)](D) Passenger vehicles as defined in subsection (2)(H) of this rule are exempt from this rule.

(2) Definitions.

(B) **Commercial Vehicle**—Any motor vehicle, other than a passenger vehicle, and any trailer, semitrailer, or pole trailer drawn by such motor vehicle, that is designed, used, and maintained for the transportation of persons or property for hire, compensation, profit, or in the furtherance of a commercial enterprise.

(3) General Provisions.

(C) Exempt idling activities. The following activities are exempt from 10 CSR 10-5.385:

1. A heavy duty diesel vehicle idling while forced to remain motionless because of road traffic, an official traffic control device or signal, or at the direction of a law enforcement official;

2. A heavy duty diesel vehicle idling when operating defrosters, heaters, air conditioners, safety lights, or other equipment solely to prevent a safety or health emergency;

3. A police, fire, ambulance, public safety, utility service vehicle, military, other emergency or law enforcement vehicle, or any heavy duty diesel vehicle being used in an emergency capacity, idling while in an emergency or training mode, and not for the convenience of the **heavy duty diesel** vehicle operator;

4. The primary propulsion engine idling for maintenance, servicing, repairing, or diagnostic purposes if idling is necessary for such activity or if idling of the primary propulsion engine is being conducted in accordance with the manufacturer's recommendations;

5. A heavy duty diesel vehicle idling as part of a state or federal inspection to verify that all equipment is in good working order, provided idling is required as part of the inspection;

6. A primary propulsion engine idling when necessary to power work-related mechanical or electrical operations other than propulsion (e.g., mixing, operating hydraulic lifts, processing cargo, or straight truck refrigeration). This exemption does not apply when idling for cabin comfort or to operate non-essential on-board equipment;

7. An armored vehicle idling when a person remains inside the vehicle to guard the contents, or while the vehicle is being loaded or unloaded;

8. A bus idling for no greater than fifteen (15) minutes in any sixty (60)-minute period to maintain passenger comfort while non-driver passengers are onboard;

9. An occupied heavy duty diesel vehicle with a sleeper berth compartment idling for purposes of air conditioning or heating during government mandated rest periods;

10. A heavy duty diesel vehicle idling due to mechanical difficulties over which the driver has no control;

11. Heavy duty diesel vehicles used exclusively for agricultural operations and only incidentally operated or moved upon public roads;

12. Operating an auxiliary power unit as an alternative to idling the main engine; and

13. A heavy duty diesel vehicle idling for no greater than thirty (30) minutes in any sixty (60)-minute period while waiting to load or unload at a freight load/unload location.

*AUTHORITY: section 643.050, RSMo 2000. Original rule filed July 11, 2008, effective Feb. 28, 2009. Amended: Filed Oct. 28, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing on this proposed amendment will begin at 9:00 a.m., February 2, 2012. The public hearing will be held at the Elm Street Conference Center, 1730 East Elm Street, Lower Level, Bennett Springs Conference Room, Jefferson City, Missouri. Opportunity to be heard at the hearing shall be afforded any interested person. Interested persons, whether or not heard, may submit a written or email statement of their views until 5:00 p.m., February 9, 2012. Written comments shall be sent to Chief, Air Quality Planning Section, Missouri Department of Natural Resources' Air Pollution Control Program, PO Box 176, Jefferson City, MO 65102-0176. Email comments shall be sent to [apcprulespn@dnr.mo.gov](mailto:apcprulespn@dnr.mo.gov).*

**Title 10—DEPARTMENT OF NATURAL RESOURCES  
Division 20—Clean Water Commission  
Chapter 7—Water Quality**

**PROPOSED AMENDMENT**

**10 CSR 20-7.031 Water Quality Standards.** The department is amending sections (1), (3), (4), (5), (6), (8), (11); adding sections (2) and (12); and renumbering sections (7), (9), (10), (13), (14), and (15) to accommodate added sections.

*PURPOSE: This rule amendment includes revisions that ensure state water quality standards are functionally equivalent to federal standards. These revisions also improve the clarity, specificity, and effectiveness of the rule. Several of the revisions are program development priorities of the Department and U.S. Environmental Protection*

Agency. Among these priorities are designation of “fishable/swimmable” uses to currently unclassified waters and updating state water quality criteria to be protective of designated beneficial uses.

**PURPOSE:** This rule identifies [beneficial] uses of waters of the state, criteria to protect those uses and defines the antidegradation policy. It is developed in response to the Missouri Clean Water Law and the federal Clean Water Act, Section 303(c)(1) and (2), which requires that state water quality standards be reviewed at least once every three (3) years. These revisions are pursuant to the national goal of protection of fish, shellfish, [and] wildlife, and recreation in and on the water as outlined in Section 101(a)(2) of the Act.

(1) Definitions.

(A) Acute toxicity—Conditions producing adverse effects or lethality on aquatic life following short-term exposure. The acute criteria in Tables A and B are maximum concentrations which protect against acutely toxic conditions. Acute toxicity is also indicated by exceedance of whole-effluent toxicity (WET) test conditions of paragraph [(3)/(4)](1)2. For substances not listed in Table A or B, **three-tenths** (0.3) of the median lethal concentration, or the no observed acute effect concentration for representative species, may be used to determine absence of acute toxicity.

[(C) Beneficial or designated uses. Those uses specified in paragraphs 1.–15. of this subsection for each water body segment whether or not they are attained. Beneficial or designated uses (1)(C)1.–11. of classified waters are identified in Tables G and H. Beneficial or designated uses (1)(C)12.–15. of classified waters must be determined on a site-by-site basis and are therefore not listed in Tables G and H.

1. Irrigation—Application of water to cropland or directly to plants that may be used for human or livestock consumption. Occasional supplemental irrigation, rather than continuous irrigation, is assumed.

2. Livestock and wildlife watering—Maintenance of conditions to support health in livestock and wildlife.

3. Cold-water fishery—Waters in which naturally occurring water quality and habitat conditions allow the maintenance of a naturally reproducing or stocked trout fishery and other naturally reproducing populations of recreationally important fish species.

4. Cool-water fishery—Waters in which naturally occurring water quality and habitat conditions allow the maintenance of a sensitive, high-quality sport fishery (including smallmouth bass and rock bass) and other naturally reproducing populations of recreationally important fish species.

5. Protection of aquatic life (General warm-water fishery)—Waters in which naturally occurring water quality and habitat conditions allow the maintenance of a wide variety of warm-water biota, including naturally reproducing populations of recreationally important fish species. This includes all Ozark Class C and P streams, all streams with 7Q10 low flows of more than one-tenth cubic foot per second (0.1 cfs), all P1 streams, and all classified lakes. However, individual Ozark Class C streams may be determined to be limited warm-water fisheries on the basis of limited habitat, losing-stream classification, land-use characteristics, or faunal studies which demonstrate a lack of recreationally important fish species.

6. Protection of aquatic life (Limited warm-water fishery)—Waters in which natural water quality and/or habitat conditions prevent the maintenance of naturally reproducing populations of recreationally important fish species. This includes non-Ozark Class C streams and non-Ozark Class P streams with 7Q10 low flows equal to or less than 0.1 cfs and Ozark Class C streams with the characteristics outlined in paragraph (1)(C)5.

7. Human health protection (Fish consumption)—Criteria to protect this use are based on the assumption of an average amount of fish consumed on a long-term basis. Protection of this use includes compliance with Food and Drug Administration (FDA) limits for fish tissue, maximum water concentrations corresponding to the  $10^{-6}$  cancer risk level, and other human health fish consumption criteria.

8. Whole body contact recreation—Activities in which there is direct human contact with the raw surface water to the point of complete body submergence. The raw water may be ingested accidentally and certain sensitive body organs, such as the eyes, ears, and the nose, will be exposed to the water. Although the water may be ingested accidentally, it is not intended to be used as a potable supply unless acceptable treatment is applied. Water so designated is intended to be used for swimming, water skiing, or skin diving. All waters in Tables G and H of this rule are presumed to support whole body contact recreation unless a Use Attainability Analysis (UAA) has shown that the use is unattainable. The use designation for whole body contact recreation may be removed or modified through a UAA for only those waters where whole body contact is not an existing use. Assignment of this use does not grant an individual the right to trespass when a land is not open to and accessible by the public through law or written permission of the landowner.

A. Category A—This category applies to those water segments that have been established by the property owner as public swimming areas allowing full and free access by the public for swimming purposes and waters with existing whole body contact recreational use(s). Examples of this category include, but are not limited to, public swimming beaches and property where whole body contact recreational activity is open to and accessible by the public through law or written permission of the landowner.

B. Category B—This category applies to waters designated for whole body contact recreation not contained within category A.

9. Secondary contact recreation—Uses include fishing, wading, commercial and recreational boating, any limited contact incidental to shoreline activities, and activities in which users do not swim or float in the water. These recreational activities may result in contact with the water that is either incidental or accidental and the probability of ingesting appreciable quantities of water is minimal. Assignment of this use does not grant an individual the right to trespass when a land is not open to and accessible by the public through law or written permission of the landowner.

10. Drinking water supply—Maintenance of a raw water supply which will yield potable water after treatment by public water treatment facilities.

11. Industrial process water and industrial cooling water—Water to support various industrial uses; since quality needs will vary by industry, no specific criteria are set in these standards.

12. Storm- and flood-water storage and attenuation—Waters which serve as overflow and storage areas during flood or storm events slowly release water to downstream areas, thus lowering flood peaks and associated damage to life and property.

13. Habitat for resident and migratory wildlife species, including rare and endangered species—Waters that provide essential breeding, nesting, feeding, and predator escape habitats for wildlife including waterfowl, birds, mammals, fish, amphibians, and reptiles.

14. Recreational, cultural, educational, scientific, and natural aesthetic values and uses—Waters that serve as recreational sites for fishing, hunting, and observing wildlife;

waters of historic or archaeological significance; waters which provide great diversity for nature observation, educational opportunities, and scientific study.

15. *Hydrologic cycle maintenance*—Waters hydrologically connected to rivers and streams serve to maintain flow conditions during periods of drought. Waters that are connected hydrologically to the groundwater system recharge groundwater supplies and assume an important local or regional role in maintaining groundwater levels.]

[(D)](C) *Biocriteria*—Numeric values or narrative expressions that describe the reference biological integrity of aquatic communities [inhabiting waters that have been designated for aquatic-life protection].

[(E)](D) *Chronic toxicity*—Conditions producing adverse effects on aquatic life or wildlife following long-term exposure but having no readily observable effect over a short time period. Chronic numeric criteria in Tables A1, A2, B2, and B3 are maximum concentrations which protect against chronic toxicity; these values shall be *considered* calculated as four (4)-day averages, with the exception of total ammonia nitrogen which shall be calculated as thirty (30)-day averages. Chronic toxicity is also indicated by exceedance of WET test conditions of subsection [(4)](5)(Q). For substances not listed in Tables A1, A2, B2, [or] and B3, commonly used endpoints such as the no-observed effect concentration or inhibition concentration of representative species may be used to demonstrate absence of toxicity.

[(F)](E) *Classified waters*—[All waters listed as L1, L2 and L3 in Table G and P, P1 and C in Table H] A category that describes the surface water hydrology of a water of the state. During normal flow periods, some rivers back water into tributaries which *are not otherwise classified* have a different class. These permanent backwater areas are considered to have the same classification as the water body into which the tributary flows.

1. Class L1—Lakes used primarily for public drinking water supply.

2. Class L2—Major reservoirs.

3. Class L3—Other lakes which are waters of the state. These include both public and private lakes. For effluent regulation purposes, publicly owned L3 lakes are those for which a substantial portion of the surrounding lands are publicly owned or managed.

4. Class P—Streams that maintain permanent flow even in drought periods.

5. Class P1—Standing-water reaches of Class P streams.

6. Class C—Streams that may cease flow in dry periods but maintain permanent pools *[which support aquatic life]*.

7. Class E—Streams that do not have permanent surface flow or permanent pools, but have periodic surface flow in response to precipitation events.

[7.8. Class W—Wetlands that are waters of the state that meet the criteria in the *Corps of Engineers Wetlands Delineation Manual* (January 1987), and subsequent federal revisions. Class W waters do not include wetlands that are artificially created on dry land and maintained for the treatment of mine drainage, stormwater control, drainage associated with road construction, or industrial, municipal, or agricultural waste. Class W determination on any specific site shall be consistent with federal law.

(F) *Designated use*—Uses specified for each water body or segment whether or not they are being attained. Uses are designated according to section (2) of this rule and may include, but are not limited to:

1. Protection and propagation of fish, shellfish, and wildlife.

A. *General warm-water fishery*—Waters in which naturally occurring water quality and habitat conditions allow the maintenance of a wide variety of warm-water biota, including naturally reproducing populations of recreationally-important fish species. This includes all Ozark Class C and P streams, all streams with 7Q10 low flows of more than one-tenth cubic foot per second (0.1 cfs), all P1 streams, and all lakes so designated

by this rule. However, individual Ozark Class C streams may be determined to be limited warm-water fisheries on the basis of limited habitat, losing-stream classification, land-use characteristics, or faunal studies which demonstrate a lack of recreationally important fish species.

B. *Cool-water fishery*—Waters in which naturally occurring water quality and habitat conditions allow the maintenance of a sensitive, high-quality sport fishery (including smallmouth bass and rock bass) and other naturally reproducing populations of recreationally important fish species.

C. *Cold-water fishery*—Waters in which naturally occurring water quality and habitat conditions allow the maintenance of a naturally reproducing or stocked trout fishery and other naturally reproducing populations of recreationally-important fish species.

D. *Limited warm-water fishery*—Waters in which natural water quality and/or habitat conditions prevent the maintenance of naturally reproducing populations of recreationally-important fish species. This may include non-Ozark Class C streams and non-Ozark Class P streams with 7Q10 low flows equal to or less than one-tenth cubic foot per second (0.1 cfs) and Ozark Class C streams with the characteristics outlined in subparagraph (1)(F)1.A. Waters designated for this use must have a demonstrated lack of support for a general warm-water fishery through a Use Attainability Analysis (UAA) conducted according to subsections (2)(E)–(G) and (2)(I) of this rule.

E. *Exceptional aquatic community (EAC)*—An aquatic community that contains a high diversity of aquatic species (fish or benthic macroinvertebrate) or contains unusual or unique assemblages of aquatic life;

2. *Recreation in and on the water*—Assignment of these uses does not grant an individual the right to trespass when a land is not open to and accessible by the public through law or written permission of the landowner.

A. *Whole body contact recreation (WBC)*—Activities involving direct human contact with waters of the state to the point of complete body submergence. The water may be ingested accidentally and certain sensitive body organs, such as the eyes, ears, and the nose, will be exposed to the water. Although the water may be ingested accidentally, it is not intended to be used as a potable supply unless acceptable treatment is applied. Water so designated is intended to be used for swimming, water skiing, or skin diving.

(I) *Category A (WBC-A)*—This category applies to waters that have been established by the property owner as public swimming areas welcoming access by the public for swimming purposes and waters with documented existing whole body contact recreational use(s) by the public. Examples of this category include, but are not limited to, public swimming beaches and property where whole body contact recreational activity is open to and accessible by the public through law or written permission of the landowner.

(II) *Category B (WBC-B)*—This category applies to waters designated for whole body contact recreation not contained within category A.

B. *Secondary contact recreation (SCR)*—Uses include fishing, wading, commercial and recreational boating, any limited contact incidental to shoreline activities, and activities in which users do not swim or float in the water. These recreational activities may result in contact with the water that is either incidental or accidental and the probability of ingesting appreciable quantities of water is minimal;

3. *Human health protection (HHP)*—Protection for the consumption of aquatic organisms or aquatic organisms and water from a single source. Criteria for this use includes compliance with Food and Drug Administration (FDA) limits for fish tissue consumption, maximum water concentrations corresponding to the 10<sup>-6</sup> cancer risk level, and other human health aquatic organism

consumption criteria such as body weight.

A. Organism only—Protection of human health for the consumption of aquatic organisms.

B. Water + organism—Protection of human health for the consumption of aquatic organisms and water;

4. Livestock and wildlife protection (LWP)—Maintenance of conditions in waters of the state to support health in livestock and wildlife;

5. Drinking water supply (DWS)—Maintenance of a raw water supply which will yield potable water after treatment by public water treatment facilities in accordance with the Federal Safe Drinking Water Act;

6. Irrigation (IRR)—Application of water to cropland or directly to cultivated plants. Occasional supplemental irrigation, rather than continuous irrigation, is assumed;

7. Industrial water supply (IND)—Water to support various industrial uses; since quality needs will vary by industry, no numeric criteria are set in these standards;

8. Runoff storage and attenuation (RSA)—Waters which serve as overflow and storage areas during flood or storm events which slowly release water to downstream areas, thus lowering flood peaks and associated damage to life and property;

9. Wildlife habitat protection (WHP)—Habitat for resident and migratory wildlife species, including rare and endangered species. Waters that provide essential breeding, nesting, feeding, and predator escape habitats for wildlife including waterfowl, birds, mammals, fish, amphibians, and reptiles. Wildlife habitat protection waters include, but are not limited to, waters in National Wildlife Refuges, wetlands, and threatened or endangered species habitat;

10. Recreational, cultural, educational, scientific, and natural aesthetic use protection (RES)—Waters that serve as special recreational sites for fishing, hunting, and observing wildlife; waters of historic or archaeological significance; waters which provide great diversity for nature observation, educational opportunities, and scientific study;

11. Hydrologic cycle maintenance (HCM)—Waters hydrologically connected to rivers and streams which serve to maintain flow conditions during periods of drought and waters that are connected hydrologically to the groundwater system, recharge groundwater supplies, and assume an important local or regional role in maintaining groundwater levels; and

12. Outstanding resource waters—Waters that are subject to tier three protection under the antidegradation rule at 10 CSR 20-7.031(3).

A. Outstanding national resource waters (ONRW)—Waters which have outstanding national recreational and ecological significance. These waters shall receive special protection against any degradation in quality. Congressionally designated rivers, including those in the Ozark National Scenic Riverways and the Wild and Scenic Rivers System, are so designated. Waters designated as ONRW can be found in Table D.

B. Outstanding state resource waters (OSRW)—High quality waters with a significant aesthetic, recreational, or scientific value which are specifically designated as such by the Clean Water Commission in accordance with 10 CSR 20-7.031(8). Waters designated as OSRW can be found in Table E.

(K) *Escherichia coli* (*E. coli*)—A type of fecal coliform bacteria found in the intestines of humans and other warm-blooded animals [and humans]. The presence of *E. coli* in water is a strong indication of recent sewage or animal waste contamination. Sewage may contain many types of disease-causing organisms (pathogens).

[(Q)] *Outstanding national resource waters*—Waters which have outstanding national recreational and ecological significance. These waters shall receive special protection against any degradation in quality. Congressionally designated rivers, including those in the Ozark national scenic riverways and the wild and scenic rivers system, are so designated (see Table D).

[(R)] *Outstanding state resource waters*—High quality waters with a significant aesthetic, recreational, or scientific value which are specifically designated as such by the Clean Water Commission (see Table E).]

[(S)](Q) Ozark streams—Streams lying within the Ozark faunal region as described in the *Aquatic Community Classification System for Missouri*, Missouri Department of Conservation, 1989.

[(T)](R) Reference lakes or reservoirs—Lakes or reservoirs determined by Missouri Department of Natural Resources to be the best available representatives of ecoregion waters in a natural condition with respect to habitat, water quality, biological integrity and diversity, watershed land use, and riparian conditions.

[(U)](S) Reference stream reaches—Stream reaches determined by the department to be the best available representatives of ecoregion waters in a natural condition, with respect to habitat, water quality, biological integrity and diversity, watershed land use, and riparian conditions.

[(V)](T) Regulated-flow streams—A stream that derives a majority of its flow from an impounded area with a flow-regulating device.

[(W)](U) Use Attainability Analysis (UAA)—A structured scientific assessment of the factors affecting the attainment of the use which may include physical, chemical, biological, and economic factors as described in 40 CFR 131.10(g).

(V) Variance—Written approval and authorization of a proposed action that knowingly will result in a lack of conformity with one (1) or more criteria of 10 CSR 20-7.031 but that is deemed necessary based on the provisions of 40 CFR 131.10(g). Variances shall be administered by the commission in accordance with section 644.061, RSMo.

[(X)](W) Water effect ratio—Appropriate measure of the toxicity of a material obtained in a site water divided by the same measure of the toxicity of the same material obtained simultaneously in a laboratory dilution water.

[(Y)](X) Water hardness—The total concentration of calcium and magnesium ions expressed as calcium carbonate. For purposes of this rule, hardness will be determined by the lower quartile (twenty-fifth percentile) value of a representative number of samples from the water body in question or from a similar water body at the appropriate stream flow conditions.

[(Z)](Y) Water quality criteria—Chemical, physical, and biological properties of water that are necessary to protect beneficial water uses.

[(AA)](Z) Waters of the state—[All rivers, streams, lakes, and other bodies of surface and subsurface water lying within or forming a part of the boundaries of the state which are not entirely confined and located completely upon lands owned, leased, or otherwise controlled by a single person or by two (2) or more persons jointly or as tenants in common and includes waters of the United States lying within the state.] See definition in section 644.016, RSMo. For purposes of this regulation, waters of the state shall not be construed to include the following:

1. Manmade waste treatment systems and effluent conveyances designed solely to treat or convey wastes, waste waters, or storm waters under a Missouri State Operating Permit, Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA), Resource Conservation and Recovery Act (RCRA), or Missouri Hazardous Waste Law, or other state or federal permitting authority; or

2. Manmade storm water control technologies and structural Best Management Practices (BMPs), including but not limited to sediment basins, wet and dry detention basins, bioremediation cells, rain gardens, and bioswales.

[(BB)](AA) Wetlands—Those areas that are inundated or saturated by surface or ground water at a frequency and duration sufficient to support, and that under normal circumstances do support, a prevalence of vegetation typically adapted for life in saturated soil conditions. Wetlands generally include swamps, marshes, bogs, and similar

areas. This definition is consistent with both the United States Army Corps of Engineers 33 CFR 328.3(b) and the United States Environmental Protection Agency 40 CFR 232.2(r).

**[(CC)](BB)** Whole effluent toxicity tests—A toxicity test conducted under specified laboratory conditions on specific indicator organisms. To estimate chronic and acute toxicity of the effluent in its receiving stream, the effluent may be diluted to simulate the computed percent effluent at the edge of the mixing zone or zone of initial dilution.

**[(DD)](CC)** Zone of initial dilution—A small area of initial mixing below an effluent outfall beyond which acute toxicity criteria must be met.

**[(EE)](DD)** Zone of passage—A continuous water route necessary to allow passage of organisms with no acutely toxic effects produced on their populations.

**[(FF)](EE)** Other definitions as set forth in the Missouri Clean Water Law and 10 CSR 20-2.010 shall apply to terms used in this rule.

## **(2) Designation of Uses.**

**(A) Rebuttable presumption.** Consistent with the presumptive beneficial use protections described by 40 CFR Part 131 and sections 101(a)(2) of the federal Clean Water Act, the commission shall presume that—

1. All perennial rivers and streams;
2. All intermittent streams with permanent pools;
3. All rivers and streams spatially represented by the one to one hundred thousand (1:100,000) scale National Hydrography Dataset (NHD); and
4. All lakes and reservoirs that spatially intersect or are connected to the flowlines of rivers and streams identified in paragraph (2)(A)3. support the following designated uses: General warm-water fishery; Human health protection; Whole body contact recreation Category B; Secondary contact recreation; Livestock and wildlife protection; and Irrigation uses, as defined in this rule. The commission shall designate such water bodies accordingly, unless this presumption is properly rebutted through a UAA as described below.

**(B)** The commission may remove a designated use that is not an existing use, as defined in this rule, or assign subcategories of a use, if a UAA conducted pursuant to 40 CFR 131.10(g) demonstrates that attaining the designated use is not feasible.

**(C)** Use designations other than those mentioned in subsection (2)(A) of this rule may be applied to waters of the state on a site-by-site basis.

**(D) Use Designation Dataset.** The department shall maintain a geospatial dataset and associated list of waters that receive use designations as described in this rule and Tables G and H. Revisions to this use designation dataset shall be approved by the commission and incorporated into rule at the next systematic review or subsequent triennial review. Meanwhile, after acquiring site-specific information documenting that either i) a particular water body falls within the rebuttable presumption described above, ii) sufficient justification exists to designate additional uses for a particular water body, or iii) that a UAA demonstrates a designated use is not attainable, the commission may, with U.S. Environmental Protection Agency (EPA) approval, incorporate into the use designation dataset any approved new or revised designated uses for such water body, and apply such designated uses in performing any permitting, enforcement, or other department action as warranted under Chapter 644, RSMo or any federal water pollution control act.

**(E)** In accordance with 40 CFR 131.10(j), a UAA must be performed when the commission—

1. Designates or has designated uses for a water body that do not include the protection of fish, shellfish, wildlife, or recreation in and on the water;
2. Wishes to remove a designated use that protects fish,

shellfish, wildlife, or recreation in and on the water; or

3. Wishes to apply sub-categories of uses that protect fish, shellfish, wildlife, or recreation in and on the water, which require less stringent criteria than section 304(a) of the Clean Water Act.

**(F)** All UAA will be conducted on a representative portion of the water body in question, and will not cause segmentation of a water unless the UAA provides sound data that the designated uses are not representative of the water body as a whole as currently identified.

**(G)** UAA intended for recreation in and on the water shall be performed in accordance with methods and procedures as found in “Missouri Recreational Use Attainability Analyses: Water Body Survey and Assessment Protocol, December 19, 2007” which is hereby incorporated by reference and does not include any later amendments or additions. The department shall maintain a copy of the referenced document and shall make it available to the public for inspection and copying at no more than the actual cost of reproduction. A copy of this document may be obtained by writing to the Department of Natural Resources, Water Protection Program, PO Box 176, Jefferson City, MO 65102.

**(H)** UAA intended for aquatic life protection shall be performed in accordance with methods and procedures approved by the commission.

**(I) Schedule of Compliance.** Notwithstanding the provisions for complying with bacteria requirements under 10 CSR 20-7.015(9)(H) and water quality based effluent limitations under 10 CSR 20-7.031(11), any new effluent limitations for discharges affected by subsection (2)(A) of this rule shall be implemented within a reasonable time schedule for achieving full compliance, as described in a permit or other legally enforceable mechanism. Such time schedule shall allow no longer than June 30, 2020, to reach full compliance.

**[(2)](3)** Antidegradation. The antidegradation policy shall provide three (3) levels of protection.

**(A) Tier One.** Public health, existing in-stream water uses, and a level of water quality necessary to protect existing uses shall be maintained and protected.

**(B) Tier Two.** For all waters of the state, if existing water quality is better than applicable water quality criteria established in these rules, that existing quality shall be fully maintained and protected. Water quality may be lowered only if the state finds, after full satisfaction of the intergovernmental coordination and public participation requirements, that the lowered water quality is necessary to allow important economic and social development in the geographical area in which the waters are located. In allowing the lowering of water quality, the state shall assure that there shall be achieved the highest statutory and regulatory requirements for all new and existing point sources and all cost-effective and reasonable best management practices for nonpoint source control before allowing any lowering of water quality. This provision allows a proposed new or modified point or nonpoint source of pollution to result in limited lowering of water quality provided that—

1. The source does not violate any of the general criteria set forth in section **[(3)](4)** of this rule, or any of the criteria for protection of beneficial uses set forth in section **[(4)](5)** of this rule;

2. The source meets all applicable technological effluent limitations and minimum standards of design for point sources or minimum pollution control practices for nonpoint sources; and

3. The lowering of water quality, in the judgment of the department, is necessary for the accommodation of important economic and social development in the geographical vicinity of the discharge. In making a preliminary determination based on socioeconomic development considerations, the department may consider the potential for regional increases in utility rates, taxation levels, or recoverable costs associated with the production of goods or services that may result



from the imposition of a strict no-degradation policy. Consideration may also be given to the possible indirect effects of a policy on per capita income and the level of employment in the geographical vicinity of the proposed pollution source. Any preliminary decision by the department to allow a limited lowering of water quality will be stated as such in a public notice issued pursuant to 10 CSR 20-6.010. Pursuant to that provision, a public hearing will be held in the geographical vicinity of the proposed pollution source, if the department determines there is significant public interest in and need for a hearing.

(C) Tier Three. There shall be no lowered water quality in outstanding national resource waters or outstanding state resource waters, as designated in Tables D and E.

(D) The three (3) levels of protection provided by the antidegradation policy in subsections (A) through (C) of this section shall be implemented according to procedures hereby incorporated by reference and known as the "Missouri Antidegradation Rule and Implementation Procedure, April 20, 2007, Revised May 7, 2008." No later amendments or additions are included. This document shall be made available to anyone upon written request to the Department of Natural Resources, Water Protection Program, Water Pollution Control Branch, PO Box 176, Jefferson City, MO 65102-0176.

**[[3]](4) General Criteria.** The following water quality criteria shall be applicable to all waters of the state at all times including mixing zones. No water contaminant, by itself or in combination with other substances, shall prevent the waters of the state from meeting the following conditions:

(A) Waters shall be free from substances in sufficient amounts to cause the formation of putrescent, unsightly, or harmful bottom deposits or prevent full maintenance of beneficial uses;

(B) Waters shall be free from oil, scum, and floating debris in sufficient amounts to be unsightly or prevent full maintenance of beneficial uses;

(C) Waters shall be free from substances in sufficient amounts to cause unsightly color or turbidity, offensive odor, or prevent full maintenance of beneficial uses;

(D) Waters shall be free from substances or conditions in sufficient amounts to result in toxicity to human, animal, or aquatic life;

(E) There shall be no significant human health hazard from incidental contact with the water;

(F) There shall be no acute toxicity to livestock or wildlife watering;

(G) Waters shall be free from physical, chemical, or hydrologic changes that would impair the natural biological community;

(H) Waters shall be free from used tires, car bodies, appliances, demolition debris, used vehicles or equipment, and solid waste as defined in Missouri's Solid Waste Law, section 260.200, RSMo, except as the use of such materials is specifically permitted pursuant to section 260.200-260.247, RSMo;

(I) Waters in mixing zones and *[unclassified]* waters which support aquatic life on an intermittent basis shall be subject to the following requirements:

1. The acute toxicity criteria of Tables A1, A2, and B1 and the requirements of subsection **[[4]](5)(B)**; and

2. The following whole effluent toxicity conditions must be satisfied:

A. Single dilution method. The percent effluent at the edge of the zone of initial dilution will be computed and toxicity tests performed at this percent effluent. These tests must show statistically insignificant mortality on the most sensitive of at least two (2) representative, diverse species; and

B. Multiple dilution method. An  $LC_{50}$  will be derived from a series of test dilutions. The computed percent effluent at the edge of the zone of initial dilution must be less than three-tenths (0.3) of the  $LC_{50}$  for the most sensitive of at least two (2) representative, diverse species.

**[[4]](5) Specific Criteria.** The specific criteria shall apply to *[classified]* waters **contained in the use designation dataset and Tables G and H of this rule**. Protection of drinking water supply is limited to surface waters designated for raw drinking water supply and aquifers. Protection of whole body contact recreation is limited to *[classified]* waters designated for that use.

(A) The maximum chronic toxicity criteria in Tables A1, A2, B2, and B3 shall apply to waters designated for the indicated uses given in **the use designation dataset and Tables G and H**. *[All Table A and B criteria are chronic toxicity criteria, except those specifically identified as acute criteria.]* Water contaminants shall not cause or contribute to concentrations in excess of these values. *[Table A values listed as health advisory levels shall be used in establishing discharge permit limits and management strategies until additional data becomes available to support alternative criteria, or other standards are established.]* However, exceptions may be granted in the following cases:

1. Permanent flow streams when the stream flow is less than 7Q10;

2. Regulated flow streams if the flow is less than the minimum release flow agreed upon by the regulating agencies;

3. For the natural and unavoidable chemical and physical changes that occur in the hypolimnion of lakes. Streams below impoundments shall meet applicable specific criteria;

4. For mixing zones.

A. The mixing zone shall be exempted from the chronic criteria requirements of this section for those components of waste that are rendered nontoxic by dilution, dissipation, or rapid chemical transformation. Acute numeric criteria of Tables A1, A2, and B1 and whole effluent acute toxicity requirements of subsection **[[3]](4)(I)** must be met at all times within the mixing zone, except within the zone of initial dilution. The following criteria do not apply to thermal mixing zones. Criteria for thermal mixing zones are listed in paragraph **[[4]](5)(D)6**.

B. The maximum size of mixing zones and zone of initial dilution will be determined as follows:

(I) Streams with 7Q10 low flows of less than **one-tenth cubic foot per second (0.1 cfs)**;—

(a) Mixing zone—not allowed; and

(b) Zone of initial dilution—not allowed;

(II) Streams with 7Q10 low flow of one-tenth to twenty **cubic foot per second (0.1-20 cfs)** *[cfs]*—

(a) Mixing zone—one-quarter (1/4) of the stream width, cross-sectional area, or volume of flow; length one-quarter (1/4) mile. If the discharger can document that rapid and complete mixing of the effluent occurs in the receiving stream, the mixing zone may be up to one-half (1/2) of the stream width, cross-sectional area, or volume of flow; and

(b) Zone of initial dilution—one-tenth (0.1) of the mixing zone width, cross-sectional area, or volume of flow;

(III) Streams with 7Q10 low flow of greater than twenty **cubic foot per second (20 cfs)** *[cfs]*—

(a) Mixing zone—one-quarter (1/4) of stream width, cross-sectional area, or volume of flow; length of one-quarter (1/4) mile; and

(b) Zone of initial dilution—one-tenth (0.1) of the mixing zone width, cross-sectional area, or volume of flow and no more than ten (10) times the effluent design flow volume unless the use of diffusers or specific mixing zone studies can justify more dilution; and

(IV) Lakes.

(a) Mixing zone—not to exceed one-quarter (1/4) of the lake width at the discharge point or one hundred feet (100') from the discharge point, whichever is less.

(b) Zone of initial dilution—not allowed.

C. A mixing zone shall not overlap another mixing zone in a manner that the maintenance of aquatic life in the body of water in the overlapping area would be further adversely affected.

D. Other factors that may prohibit or further limit the size and location of mixing zones are the size of the river, the volume of discharge, the stream bank configuration, the mixing velocities, other hydrologic or physiographic characteristics, and the designated uses of the water, including type of aquatic life supported, potential effects on mouths of tributary streams, and proximity to water supply intakes.

E. Zones of passage must be provided wherever mixing zones are allowed.

F. Mixing zone and zone of initial dilution size limits will normally be based on streams at the 7Q10 low flow. However, this percent of stream size limits also applies at higher stream flows and discharge limitations may be based on higher stream flows if discharge volume or quality may be adjusted to correlate with stream flow; and

5. For wetlands. Water quality needs will vary depending on the individual characteristics of wetlands. Application of numeric criteria will depend on the specific aquatic life, wildlife, and vegetation requirements.

A. Specific criteria for wetlands shall be developed using scientific procedures including, but not limited to, those procedures described in the U.S. Environmental Protection Agency's *Water Quality Standards Handbook*, Second Edition, August 1994.

B. Specific criteria shall protect all life stages of species associated with wetlands and prevent acute and chronic toxicity in all parts of the wetland.

C. Specific criteria shall include both chronic and acute concentrations to better reflect the different tolerances to the inherent variability between concentrations and toxicological characteristics of a condition.

D. Specific criteria shall be clearly identified as maximum "not to be exceeded" or average values, and if an average, the averaging period and the minimum number of samples. The conditions, if any, when the criteria apply shall be clearly stated (e.g., specific levels of hardness, pH, or water temperature). Specific sampling requirements (e.g., location, frequency), if any, shall also be identified.

E. The data, testing procedures, and application (safety) factors used to develop specific criteria shall reflect the nature of the condition (e.g., persistency, bioaccumulation potential) and the most sensitive species associated with the wetland.

F. Each specific criterion shall be promulgated in rule 10 CSR 20-7.031. The public notice shall include a description of the affected wetland and the reasons for applying the proposed criterion. A public hearing may be held in the geographical vicinity of the affected wetland. Any specific criterion promulgated under these provisions is subject to U.S. EPA approval prior to becoming effective.

#### (B) Toxic Substances.

1. Water contaminants shall not cause the criteria in Tables A1, A2, A3, B1, B2, and B3 to be exceeded. Concentrations of these substances in bottom sediments or waters shall not harm benthic organisms and shall not accumulate through the food chain in harmful concentrations, nor shall state and federal maximum fish tissue levels for fish consumption be exceeded. More stringent criteria may be imposed if there is evidence of additive or synergistic effects.

2. For compliance with this rule, metals shall be analyzed by the following methods:

A. Aquatic life protection and human-health protection—fish consumption.

(I) Mercury—total recoverable metals.

(II) All other metals—dissolved metals;

B. Drinking water supply—total recoverable metals; and

C. All other beneficial uses—total recoverable metals.

3. Other potentially toxic substances for which sufficient toxicity data are not available may not be released to waters of the state until safe levels are demonstrated through adequate bioassay studies.

4. Drinking water criteria, for substances which are rendered nontoxic by transformation processes in the surface water body, shall apply at water supply withdrawal points.

5. Site-specific alternative criteria for human health-fish consumption may be allowed. Designation of these site-specific criteria must follow the established variance request process.

6. Metals criteria for which toxicity is hardness dependent are in equation format in Table A2.

7. Total ammonia nitrogen. For any given sample, the total ammonia nitrogen criteria shall be based on the pH and temperature of the water body measured at the time of each sample at the point of compliance.

A. The acute criteria shall not be exceeded at any time except in those waters for which the department has allowed a zone of initial dilution (ZID). The one (1)-day  $Q_{10}$  low flow condition will be used in determining acute total ammonia nitrogen criteria.

B. The chronic criteria shall not be exceeded except in water segments for which the department has allowed a mixing zone (MZ). The chronic criteria shall be based on a thirty (30)-day exposure period. Therefore, the thirty (30)-day  $Q_{10}$  low flow condition of the receiving water body will be used in determining chronic total ammonia nitrogen criteria.

C. Without sufficient and reliable data, it is assumed that early life stages are present and must be protected at all times of the year.

(I) Sufficient and reliable data shall include, but are not limited to, seasonal studies on the fish species distributions, spawning periods, nursery periods, duration of sensitive life stages, and water body temperature. Best professional judgment from fisheries biologists and other scientists will be considered as appropriate.

(II) The time frames during the year when early life stages are considered to be absent are those time periods when early life stages are present in numbers that, if chronic toxicity did occur, would not affect the long-term success of the populations.

(III) A source of information for determining the duration of early life stages is *The American Society for Testing and Materials (ASTM) Standard E-1241*, "Standard Guide for Conducting Early Life-Stage Toxicity Tests with Fishes."

(IV) Protection of early life stages should include the most sensitive species that have used a water body for spawning and rearing since November 28, 1975.

(C) Bacteria. The protection of whole body contact recreation is limited to [classified] waters designated for that use. The recreational season is from April 1 to October 31. *[The E coli count shall not exceed the criterion listed in Table A as a geometric mean during the recreational season in waters designated for whole body contact recreation. The E coli count shall not exceed one hundred twenty-six (126) per one hundred milliliters (100 mL) at any time in losing streams. For waters designated for secondary contact recreation, the E coli count shall not exceed one thousand one hundred thirty-four (1,134) per one hundred milliliters (100 mL) as a geometric mean during the recreational season.]*

1. The *E. coli* count shall not exceed one hundred twenty-six (126) per one hundred milliliters (100 mL) of water as a geometric mean during the recreational season in waters designated for WBC-A.

2. The *E. coli* count shall not exceed two hundred six (206) per one hundred milliliters (100 mL) of water as a geometric mean during the recreational season in waters designated for WBC-B.

3. The *E. coli* count shall not exceed one thousand one hundred thirty-four (1,134) per one hundred milliliters (100 mL) of water as a geometric mean during the recreational season in waters designated for SCR.

4. The *E. coli* count shall not exceed one hundred twenty-six (126) per one hundred milliliters (100 mL) of water at any time in losing streams.

## (D) Temperature.

1. For general and limited warm-water fisheries beyond the mixing zone, water contaminant sources and physical alteration of the water course shall not raise or lower the temperature of a stream more than five degrees Fahrenheit (5 °F) or two and seven-ninths degrees Celsius (2 7/9 °C). Water contaminant sources shall not cause or contribute to stream temperature in excess of ninety degrees Fahrenheit (90 °F) or thirty-two and two-ninths degrees Celsius (32 2/9 °C). However, site-specific ambient temperature data and requirements of sensitive resident aquatic species will be considered, when data are available, to establish alternative maxima or deviations from ambient temperatures.

2. For cool-water fisheries beyond the mixing zone, water contaminant sources and physical alteration of the water course shall not raise or lower the temperature of a stream more than five degrees Fahrenheit (5 °F) or two and seven-ninths degrees Celsius (2 7/9 °C). Water contaminant sources shall not cause or contribute to stream temperature in excess of eighty-four degrees Fahrenheit (84 °F) or twenty-eight and eight-ninths degrees Celsius (28 8/9 °C).

3. For cold-water fisheries beyond the mixing zone, water contaminant sources and physical alteration of the water course shall not raise or lower the temperature of the water body more than two degrees Fahrenheit (2 °F) or one and one-ninth degrees Celsius (1 1/9 °C). Water contaminant sources shall not cause or contribute to temperatures above sixty-eight degrees Fahrenheit (68 °F) or twenty degrees Celsius (20 °C).

4. Water contaminant sources shall not cause any measurable rise in the temperature of lakes. An increase is allowable for Lake Springfield, Thomas Hill Reservoir, and Montrose Lake; however, discharges from these lakes must comply with temperature limits for streams.

5. For the Mississippi River Zones 1A and 2, the water temperature outside the mixing zone shall not exceed the maximum limits indicated in the following list during more than one percent (1%) of the time in any calendar year. In Zone 1B, limits may not be exceeded more than five percent (5%) of the time in a calendar year. At no time shall the river water temperature outside of the thermal mixing zone exceed the listed limits by more than three degrees Fahrenheit (3 °F) or one and six-ninths degrees Celsius (1 6/9 °C).

	A and B		C	
	(°F)	(°C)	(°F)	(°C)
January	45	7 2/9	50	10
February	45	7 2/9	50	10
March	57	13 8/9	60	15 5/9
April	68	20	70	21 1/9
May	78	25 5/9	80	26 6/9
June	86	30	87	30 5/9
July	88	31 1/9	89	31 6/9
August	88	31 1/9	89	31 6/9
September	86	30	87	30 5/9
October	75	23 8/9	78	25 5/9
November	65	18 3/9	70	21 1/9
December	52	11 1/9	57	13 8/9

A = Zone 1A—Des Moines River to Lock and Dam No. 25.

B = Zone 1B—Lock and Dam No. 25 to Lock and Dam No. 26.

C = Zone 2—Lock and Dam No. 26 to the Missouri-Arkansas state line.

6. Thermal mixing zones shall be limited to twenty-five percent (25%) of the cross-sectional area or volume of a river, unless biological surveys performed in response to section 316(a) of the federal Clean Water Act (or equivalent) indicate no significant adverse impact on aquatic life. Thermal plume lengths and widths within rivers, and all plume dimensions within lakes, shall be determined on a case-by-case basis and shall be based on physical and biological surveys when appropriate.

(E) pH. Water contaminants shall not cause pH to be outside of the range of 6.5 to 9.0 standard pH units.

(F) Taste- and Odor-Producing Substances. Taste- and odor-producing substances shall be limited to concentrations in the streams or lakes that will not interfere with beneficial uses of the water. For those streams and lakes designated for drinking water supply use, the taste- and odor-producing substances shall be limited to concentrations that will not interfere with the production of potable water by reasonable water treatment processes.

(G) Turbidity and Color. Water contaminants shall not cause or contribute to turbidity or color that will cause substantial visible contrast with the natural appearance of the stream or lake or interfere with beneficial uses.

(H) Solids. Water contaminants shall not cause or contribute to solids in excess of a level that will interfere with beneficial uses. The stream or lake bottom shall be free of materials which will adversely alter the composition of the benthos, interfere with the spawning of fish or development of their eggs or adversely change the physical or chemical nature of the bottom.

(I) Radioactive Materials. All streams and lakes shall conform to state and federal limits for radionuclides established for drinking water supply.

(J) Dissolved Oxygen. Water contaminants shall not cause the dissolved oxygen to be lower than the levels described in Table A3 or Table K—Site-Specific Criteria.

(K) Total Dissolved Gases. Operation of impoundments shall not cause the total dissolved gas concentrations to exceed one hundred ten percent (110%) of the saturation value for gases at the existing atmospheric and hydrostatic pressures.

(L) Sulfate and Chloride Limit for Protection of Aquatic Life. **Water contaminants shall not cause sulfate or chloride criteria to exceed the levels described in Table A2.**

*[1. Streams with 7Q10 low flow of less than one (1) cubic foot per second. The concentration of chloride plus sulfate shall not exceed one thousand milligrams per liter (1,000 mg/L). Table A includes additional chloride criteria.]*

*2. Class P1, L1, L2, and L3 waters and streams with 7Q10 low flow of more than one (1) cubic foot per second. The total chloride plus sulfate concentration shall not exceed the estimated natural background concentration by more than twenty percent (20%) at the 60Q10 low flow.]*

(M) Carcinogenic Substances. Carcinogenic substances shall not exceed concentrations in water which correspond to the 10<sup>-6</sup> cancer risk rate. This risk rate equates to one (1) additional cancer case in a population of one (1) million with lifetime exposure. Derivation of this concentration assumes average water and fish consumption amounts. Assumptions are two (2) liters of water and **six and one-half (6.5)** grams of fish consumed per day. Federally established final maximum contaminant levels for drinking water supply shall supersede drinking water supply criteria developed in this manner.

(N) Nutrients and Chlorophyll.

## 1. Definitions.

A. For the purposes of this rule—

(I) All lakes and reservoirs shall be referred to as “lakes/.”; and

(II) Only total phosphorus (TP) criteria are derived from lake characteristics. Total nitrogen (TN) and chlorophyll (Chl) criteria are determined as a function of TP criteria.

B. Lake ecoregions—Due to differences in topography, soils, and geology, nutrient criteria for lakes and reservoirs will be determined by the use of four (4) major ecoregions. These regions were delineated by grouping the ecological subsections described in Nigh and Schroeder, 2002, *Atlas of Missouri Ecoregions*, Missouri Department of Conservation as follows:

(I) Plains: TP2—Deep Loess Hills; TP3—Loess Hills; TP4—Grand River Hills; TP5—Chariton River Hills; TP6—Claypan Till Plains; TP7—Wyaconda River Dissected Till Plains; TP8—Mississippi River Hills;

(II) Ozark Border: MB2a—Crowley's Ridge Loess Woodland/Forest Hills; OZ11—Prairie Ozark Border; OZ12—Outer Ozark Border; OZ13—Inner Ozark Border;

(III) Ozark Highland: OZ1—Springfield Plain; OZ2—Springfield Plateau; OZ3—Elk River Hills; OZ4—White River Hills; OZ5—Central Plateau; OZ6—Osage River Hills; OZ7—Gasconade River Hills; OZ8—Meramec River Hills; OZ9—Current River Hills; OZ10—St. Francois Knobs and Basins; OZ14—Black River Ozark Border;

(IV) Big River Floodplain: MB1—Black River Alluvial Plain; MB2b—Crowley's Ridge Footslopes and Alluvial Plains; MB3—St. Francis River Alluvial Plain; MB4, OZ16, TP9—Mississippi River Alluvial Plain; OZ15, TP1—Missouri River Alluvial Plain.

C. Criteria values.

(I) Prediction value—A TP concentration that is derived from the characteristics of a lake including dam height in feet, hydraulic residence time in years, and percentage of the watershed that was historically covered by prairie grasses. Prediction values for total phosphorus are calculated directly from these characteristics.

(II) Reference value—A TP concentration that is representative of lakes within an ecoregion having the following characteristics:

(a) Less than twenty percent (20%) of the watershed is in crop land and urban land combined;

(b) There are no point source wastewater discharges and no concentrated animal feeding operations within the watershed;

(c) In the Plains region, more than fifty percent (50%) of the watershed is in grass land; and

(d) In the Ozark Highlands region, more than fifty percent (50%) of the watershed is in woodland.

(III) Site-Specific Value—A TP concentration for a lake that has been identified as having trophic characteristics for which the reference of the ecoregion and the prediction values for that water body are not adequate to prevent deterioration of water quality. Site-specific criteria are applicable to lakes having a geometric mean TP concentration equal to or less than the 10th percentile value of the range of geometric mean TP concentrations measured in reference lakes within a lake ecoregion. Site-specific criteria are also applicable to lakes with actual TP geometric mean concentrations that are at or below the reference value where the prediction value is at or below the 10th percentile for TP geometric mean concentrations within a lake ecoregion. The 10th percentile values for each ecoregion are listed in Table L and lakes with site-specific criteria are listed in Tables M and N.

D. Tributary arm—A substantial segment of an L2 lake that is primarily recharged by a source or sources other than the main channel of the lake.

2. This rule applies to all lakes and reservoirs that are waters of the state and that are outside the Big River Floodplain ecoregion and have an area of at least ten (10) acres during normal pool.

3. Nutrient criteria for lakes and reservoirs with site-specific criteria are listed in Tables M and N. Nutrient criteria for other lakes are as follows:

A. Total phosphorus (TP)—

(I) For lakes in which the TP prediction value or the actual TP concentration does not exceed the reference value listed in Table L, the TP criterion shall be the reference value, except as described below;

(II) For lakes in which the TP prediction value does not exceed the reference value, and the actual TP value does not exceed the prediction value, the TP criterion shall be the prediction value;

(III) For lakes in which the TP prediction value and the actual TP concentration exceed the reference value listed in Table L, the TP criterion shall be limited to the prediction value; and

(IV) Site-specific TP criteria for the tributary arms of L2 lakes are listed in Table N/./;

B. Total nitrogen (TN)—

(I) For lakes in which the TP prediction value does not exceed the reference value listed in Table L, TN concentration shall be limited to twenty (20) times the TP reference value;

(II) For lakes in which the TP prediction value does not exceed the reference value, and the actual TP value does not exceed the prediction value, TN concentration shall be limited to twenty (20) times the TP prediction value;

(III) For lakes in which the TP prediction value exceeds the TP reference value listed in Table L, TN concentration shall be limited to twenty (20) times the TP prediction value; and

(IV) This portion of the rule does not apply to lakes that are held to site-specific criteria for TP, TN, and Chl, as listed in Tables M and N/./; and

C. Chlorophyll (Chl)—Chl criteria shall be calculated from TP criteria as follows:

(I) Plains: Chl:TP = 0.44;

(II) Ozark Border and Ozark Highlands: Chl:TP = 0.42; and

(III) This portion of the rule does not apply to lakes that are held to site-specific criteria for TP, TN, and Chl, as listed in Tables M and N.

4. All TP, TN, and chlorophyll concentrations must be calculated as the geometric mean of a minimum of four (4) representative samples per year for four (4) years that are not necessarily consecutive. All samples must be collected from the surface, near the outflow end of the lake, and during the period May 1–August 31.

(O) All methods of sample collection, preservation, and analysis used in applying criteria in these standards shall be in accord with those prescribed in the latest edition of *Standard Methods for the Examination of Water and Wastewater* or other procedures approved by the [Environmental Protection Agency] EPA and the Missouri Department of Natural Resources.

(P) Criteria to protect designated uses are based on current technical literature, especially the [Environmental Protection Agency's] EPA's publications, [Quality Criteria for Water, 1986] National Recommended Water Quality Criteria (2009) and 2011 Edition of the Drinking Water Standards and Health Advisories. Criteria may be modified or expanded as additional information is developed or as needed to define narrative criteria for particular situations or locations.

(Q) WET Chronic Tests. Chronic WET tests performed at the percent effluent at the edge of the mixing zone shall not be toxic to the more sensitive of at least two (2) representative, diverse species. Pollutant attenuation processes such as volatilization and biodegradation which may occur within the allowable mixing zone will be considered in interpreting results.

(R) Biocriteria. The biological integrity of waters, as measured by lists or numeric diversity indices of benthic invertebrates, fish, algae, or other appropriate biological indicators, shall not be significantly different from reference waters. Waters shall be compared to reference waters of similar size within an ecoregion. Reference water locations are listed in Table I.

(S) Site-Specific Criteria Development for the Protection of Aquatic Life. When water quality criteria in this regulation are either underprotective or overprotective of water quality due to natural, non-anthropogenic conditions for a given water body segment, a petitioner may request site-specific criteria. The petitioner must provide the department with sufficient documentation to show that the current criteria are not adequate and that the proposed site-specific criteria will protect all existing and/or potential uses of the water body.

1. Site-specific criteria may be appropriate where, but is not limited to the examples given in subparagraphs A. or B. of this paragraph/./.

A. The resident aquatic species of the selected water body have a different degree of sensitivity to a specific pollutant as compared to those species in the data set used to calculate the national or state criteria as described in either of the following parts:

(I) Natural adaptive processes have enabled a viable, balanced aquatic community to exist in waters where natural (non-anthropogenic) background conditions exceed the criterion (e.g., resident species have evolved a genetically based greater tolerance to high concentrations of a chemical); or

(II) The composition of aquatic species in a water body is different from those used in deriving a criterion (e.g., most of the species considered among the most sensitive, such as salmonids or the cladoceran, *Ceriodaphnia dubia*, which were used in developing a criterion, are absent from a water body).

B. The physical and/or chemical characteristics of the water body alter the biological availability and/or toxicity of the pollutant (e.g., pH, alkalinity, salinity, water temperature, hardness).

2. All petitioners seeking to develop site-specific criteria shall coordinate with the department early in the process. This coordination will insure the use of adequate, relevant, and quality data; proper analysis and testing; and defensible procedures. The department will provide guidance for establishing site-specific water quality criteria using scientific procedures including, but not limited to, those procedures described in the *U.S. Environmental Protection Agency's/ EPA's Water Quality Standards Handbook*, Second Edition, August 1994.

3. Site-specific criteria shall protect all life stages of resident species and prevent acute and chronic toxicity in all parts of a water body.

4. Site-specific criteria shall include both chronic and acute concentrations to better reflect the different tolerances of resident species to the inherent variability between concentrations and toxicological characteristics of a chemical.

5. Site-specific criteria shall be clearly identified as maximum "not to be exceeded" or average values, and if an average, the averaging period and the minimum number of samples. The conditions, if any, when the criteria apply shall be clearly stated (e.g., specific levels of hardness, pH, or water temperature). Specific sampling requirements (e.g., location, frequency), if any, shall also be identified.

6. The data, testing procedures, and application (safety) factors used to develop site-specific criteria shall reflect the nature of the chemical (e.g., persistency, bioaccumulation potential, and avoidance or attraction responses in fish) and the most sensitive resident species of a water body.

7. The size of a site may be limited to a single water segment, single water subsegment, or may cover a whole watershed depending on the particular situation for which the specific criterion is developed. A group of water bodies may be considered one (1) site if their respective aquatic communities are similar in composition and have comparable water quality.

8. The department shall determine if a site-specific criterion is adequate and justifiable. Each site-specific criterion shall be promulgated into rule 10 CSR 20-7.031. The public notice shall include a description of the affected water body or water body segment and the reasons for applying the proposed criterion. If the department determines that there is significant public interest, a public hearing may be held in the geographical vicinity of the affected water body or water body segment. Any site-specific criterion promulgated under these provisions is subject to U.S. EPA approval prior to becoming effective.

#### //(5)/(6) Groundwater.

(A) Water contaminants shall not cause or contribute to *[exceedence]* **exceedance** of Table A1 *[groundwater limits]* **drinking water supply (DWS) criteria**, in aquifers and caves. Table A1 values listed as health advisory levels shall be used in establishing management strategies and groundwater cleanup criteria, until additional data becomes available to support alternative criteria or other standards are established. Substances not listed in Table A1 shall be limited so that drinking water, livestock watering, and irrigation uses are protected.

(B) When criteria for the protection of aquatic life or human health protection-fish consumption in Table A1 are more stringent than groundwater criteria, appropriate criteria for the protection of aquatic life or human health protection-fish consumption shall apply to waters in caves and to aquifers which contribute an important part of base flow of surface waters designated for aquatic life protection. Other substances not listed in Table A1 shall be limited in these aquifers and caves so that the aquatic life use is protected.

(C) Groundwater and other criteria shall apply in any part of the aquifer, including the point at which the pollutant enters the aquifer. A specific monitoring depth requirement for releases to aquifers is included in 10 CSR 20-7.015(7)(A).

(D) For aquifers in which contaminant concentrations exceed groundwater criteria or other protection criteria, and existing and potential uses are not impaired, alternative site-specific criteria may be allowed. To allow alternative criteria, the management authority must demonstrate that alternative criteria will not impair existing and potential uses. The demonstration must consider the factors and be subject to the review requirements of 10 CSR 20-7.015(7)(F).

//(6)/(7) Metropolitan No-Discharge Streams. No water contaminant except uncontaminated cooling water, permitted stormwater discharges in compliance with permit conditions and excess wet-weather bypass discharges not interfering with beneficial uses, shall be discharged to the watersheds of streams listed in Table F. Existing interim discharges may be allowed until interceptors are available within two thousand feet (2,000') or a distance deemed feasible by the department, or unless construction of outfalls to alternative receiving waters not listed in Table F is deemed feasible by the department. Existing discharges include wastewater volumes up to the design capacity of existing permitted treatment facilities, including phased increases in design capacity approved by the department prior to the effective date of this rule. Additional facilities may be constructed to discharge to these waters only if they are intended to be interim facilities in accordance with a regional wastewater treatment plan approved by the department.

//(7)/(8) Outstanding National Resource Waters. Under section // (2)/(3), antidegradation section of this rule, new releases to outstanding national resource waters from any source are prohibited and releases from allowed facilities are subject to special effluent limitations as required in 10 CSR 20-7.015(6). Table D contains a list of the outstanding national resource waters in Missouri.

//(8)/(9) Outstanding State Resource/s/ Waters. The commission wishes to recognize certain high-quality waters that may require exceptionally stringent water-quality management requirements to assure conformance with the antidegradation policy. The degree of management requirements will be decided on an individual basis. To qualify for inclusion, all of the following criteria must be met. The waters listed in Table E must—

(A) Have a high level of aesthetic or scientific value;

(B) Have an undeveloped watershed; and

(C) Be located on or pass through lands which are state or federally owned, or which are leased or held in perpetual easement for conservation purposes by a state, federal, or private conservation agency or organization.

//(9)/(10) Lake Taneycomo. The commission wishes to recognize the uniqueness of Lake Taneycomo with respect to its high water clarity, its importance as a trout fishery and as the central natural resource in the rapidly developing Branson area and threats to the lake's water quality imposed by development. An especially stringent antidegradation policy will be observed in the development of effluent rules, discharge permits, and nonpoint-source management plans and permits to assure that the high visual quality and aquatic resources are maintained. The use of the best treatment technology for point- and nonpoint-source discharges in the lake's watershed between Table

Rock Lake and Power Site Dam will be the guiding principle in establishing limitations.

**[(10)](11) Compliance with Water Quality Based Limitations.** Compliance with new or revised National Pollutant Discharge Elimination System (NPDES) or Missouri operating permit limitations based on criteria in this rule shall be achieved with all deliberate speed *[no later than three (3) years from the date of issuance of the permit except where provided for otherwise in 10 CSR 20-7.015(9)(H).]* and in accordance with federal regulation at 40 CFR Part 122.47, "Schedules of Compliance," May 15, 2000, as published by the Office of the Federal Register, National Archives and Records Administration, Superintendent of Documents, Pittsburgh, PA 15250-7954, which is hereby incorporated by reference and does not include any later amendments or additions. The department shall maintain a copy of the referenced document and shall make it available to the public for inspection and copying at no more than the actual cost of reproduction. Variances from water quality based limitations may be requested in accordance with section (12) of this rule.

**(12) Variances.**

(A) The department may grant, to an applicant for a NPDES or Missouri operating permit, a variance to a water quality-based effluent limitation or water quality standard found in the operating permit.

1. A variance applies only to the permittee identified in such variance and only to the pollutant or water quality standard specified in the variance. A variance does not affect or require the department to modify a corresponding standard or criteria value.

2. A variance shall not be granted if standards or criteria values will be attained by implementing technology-based effluent limits required under 10 CSR 20-7.015 of this rule and by implementing cost-effective and reasonable best management practices for nonpoint-source control.

3. A variance shall not be granted for actions that will impact water quality and conditions protected by 10 CSR 20-7.031(4).

4. A variance shall be not be granted that would likely jeopardize the continued existence of any endangered or threatened species or result in the destruction or adverse modification of such species' critical habitat.

(B) A variance may be granted if the applicant demonstrates that achieving the water quality-based effluent limitation or water quality standard is not feasible as supported by an analysis considering the provisions of 40 CFR 131.10(g).

(C) In granting a variance, conditions and time limitations may be set by the department with the intent that progress be made toward improvements in surface water quality.

(D) Each variance shall be granted only after public notification and opportunity for public comment. Each variance, once granted, shall be approved by the EPA prior to implementation for Clean Water Act purposes. Each variance shall be adopted into rule at the next systematic review or subsequent triennial review.

**[(11)](13) Losing Streams.**

(A) Losing stream determinations will usually be made upon the first application for discharge to a specific water or location within a watershed for a wastewater treatment facility, subdivision development, or animal waste management facility.

(B) Permits or other approvals for those applications will be processed in accordance with the determinations. Additional permits or approvals will be processed in accordance with the latest determination.

(C) For application purposes, any proposed facility within five (5) miles of a known losing stream segment should presume that facility's receiving stream segment is also losing until and unless a specific geologic evaluation is made of that stream and concludes the stream segment is gaining.

(D) Existing facilities operating under a state operating permit and new facilities being constructed under a construction permit in proximity to stream segments subsequently determined to be losing will be allowed to continue in operation at permitted or approved effluent limits for a period of time lasting the design life of the facility (usually twenty (20) years from the original construction completion), provided the facility is in compliance with its effluent limits and remains in compliance with those limits[,] and if neither of the following conditions is present:

1. If the discharge from such a facility can be eliminated by connection to a locally available facility, the facility shall be connected within three (3) years of the losing stream determination. A local facility shall be considered available if that facility or an interceptor is within two thousand feet (2000') or a distance deemed feasible by the department; and

2. If the discharge from such a facility is shown to cause pollution of groundwater, the facility shall be upgraded to appropriate effluent standards within three (3) years. The department shall include appropriate groundwater monitoring requirements in permits for any such facilities so that pollution, should it occur, would be detected.

(E) Any additional permits or approvals for increased treatment plant design capacity will be processed in accordance with the newest losing stream determination. No additional permits or approvals for any facilities shall be construed as lengthening the time for compliance with losing stream effluent limitations as established in subsection [(11)](13)(D).

**[(12)](14) Severance.** If a section, subsection, paragraph, sentence, clause, phrase, or any part of this rule be declared unconstitutional or invalid for any reason, the remainder of this rule shall not be affected and shall remain in full force and effect.

**[(13)](15) Effective Date.** This rule becomes effective immediately upon adoption and compliance with the requirements of subsection 644.036.3, of the Missouri Clean Water Law and Chapter 536, RSMo.

[Table A—Criteria for Designated Uses

WBC = Whole Body Contact Recreation  
 SCR = Secondary Contact Recreation  
 AQL = Protection of Aquatic Life  
 DWS = Drinking Water Supply  
 LWW = Livestock and Wildlife Watering  
 GRW = Groundwater

Pollutant (µg/L)	AQL
Chlorine (total residual)	
cold-water	2
warm-water chronic—	10
acute—	19
Cyanide (amenable to chlorination)	
chronic—	5
acute—	22
Hydrogen sulfide (un-ionized)	2

Pollutant (mg/L)	AQL	DWS	LWW	GRW
Chloride chronic—	230(+)	250		
acute—	860(+)			
Sulfate (+)		250		
Fluoride		4	4	4
Nitrate-N		10		10
Dissolved oxygen (minimum)*				
warm-water and cool-water fisheries	5			
cold-water fisheries	6			
Oil and grease	10			

+ See 10 CSR 20-7.031(4)(L).

\* Site-Specific Criteria have been promulgated for waters listed in Table K.

Pollutant (/100 mL)	WBC-A	WBC-B	SCR
E coli Bacteria**	126	206	1134

\*\*Geometric mean during the recreational season in waters designated for recreation or at any time in losing streams. The recreational season is from April 1 to October 31.

Pollutant	AQL	
Temperature (maximum)	°F	°C
warm-water	90	32 2/9
cool-water	84	28 8/9
cold-water	68	20
Temperature (maximum change)		
warm-water	5	2 7/9
cool-water	5	2 7/9
cold-water	2	1 6/9

Pollutant (percent saturation)	AQL
Total Dissolved Gases	110%



AQL = Protection of Aquatic Life  
HHF = Human Health Protection-Fish Consumption  
DWS = Drinking Water Supply  
IRR = Irrigation  
LWW = Livestock Wildlife Watering  
GRW = Groundwater

Pollutant (µg/L)	AQL	HHF	DWS	IRR	LWW	GRW
<i>Metals (refer to text in 10 CSR 20-7.031(4)(B)2.) (Not Hardness Dependant)</i>						
Aluminum (acute)	750					
Antimony		4,300	6			6
Arsenic	20		50	100		50
Barium			2,000			2,000
Beryllium	5		4	100		4
Boron				2,000		2,000
Cadmium	*		5			5
Chromium III	*		100	100		100
Chromium VI						
chronic	10					
acute	15					
Cobalt					1,000	1,000
Copper	*		1,300		500	1,300
Iron	1,000					300
Lead	*		15			15
Manganese						50
Mercury			2			2
chronic	0.5					
acute	2.4					
Nickel	*		100			100
Selenium	5		50			50
Silver	*		50			50
Thallium		6.3	2			2
Zinc	*		5,000			5,000

\*See Metals (Hardness Dependent)

AQL = Protection of Aquatic Life

Pollutant (µg/L)	AQL	
Metals (Hardness Dependent)		
Cadmium (µg/L)	Acute:	$e^{(1.0166 \cdot \ln(\text{Hardness}) - 3.062490)} * (1.136672 - (\ln(\text{Hardness}) * 0.041838))$
	Chronic:	$e^{(0.7409 \cdot \ln(\text{Hardness}) - 4.719948)} * (1.101672 - (\ln(\text{Hardness}) * 0.041838))$
Chromium III (µg/L)	Acute:	$e^{(0.8190 \cdot \ln(\text{Hardness}) + 3.725666)} * 0.316$
	Chronic:	$e^{(0.8190 \cdot \ln(\text{Hardness}) + 0.684960)} * 0.860$
Copper (µg/L)	Acute:	$e^{(0.9422 \cdot \ln(\text{Hardness}) - 1.700300)} * 0.960$
	Chronic:	$e^{(0.8545 \cdot \ln(\text{Hardness}) - 1.702)} * 0.960$
Lead (µg/L)	Acute:	$e^{(1.273 \cdot \ln(\text{Hardness}) - 1.460448)} * (1.46203 - (\ln(\text{Hardness}) * 0.145712))$
	Chronic:	$e^{(1.273 \cdot \ln(\text{Hardness}) - 4.704797)} * (1.46203 - (\ln(\text{Hardness}) * 0.145712))$
Nickel (µg/L)	Acute:	$e^{(0.8460 \cdot \ln(\text{Hardness}) + 2.255647)} * 0.998$
	Chronic:	$e^{(0.8460 \cdot \ln(\text{Hardness}) + 0.058978)} * 0.997$
Silver (µg/L)	Acute:	$e^{(1.72 \cdot \ln(\text{Hardness}) - 6.588144)} * 0.850$
Zinc (µg/L)	Acute:	$e^{(0.8473 \cdot \ln(\text{Hardness}) + 0.884)} * 0.98$
	Chronic:	$e^{(0.8473 \cdot \ln(\text{Hardness}) + 0.884)} * 0.98$

	Hardness								
	50–74	75–99	100–124	125–149	150–174	175–199	200–224	225–249	250+
<i>Cadmium</i>									
<i>Acute:</i>	2.4	3.6	4.8	5.9	7.1	8.2	9.4	10.5	11.6
<i>Chronic:</i>	0.2	0.2	0.3	0.3	0.3	0.4	0.4	0.4	0.5
<i>Chromium III</i>									
<i>Acute:</i>	323	450	570	684	794	901	1,005	1,107	1,207
<i>Chronic:</i>	42	59	74	89	103	117	131	144	157
<i>Copper</i>									
<i>Acute:</i>	7	10	13	17	20	23	26	29	32
<i>Chronic:</i>	5	7	9	11	13	14	16	18	20
<i>Lead</i>									
<i>Acute:</i>	30	47	65	82	100	118	136	154	172
<i>Chronic:</i>	1	2	3	3	4	5	5	6	7
<i>Nickel</i>									
<i>Acute:</i>	261	367	469	566	660	752	842	930	1,017
<i>Chronic:</i>	29	41	52	63	73	84	94	103	113
<i>Silver</i>									
<i>Acute:</i>	1.0	2.0	3.2	4.7	6.5	8.4	10.6	13.0	15.6
<i>Zinc</i>									
<i>Acute:</i>	65	92	117	142	165	188	211	233	255
<i>Chronic:</i>	65	92	117	142	165	188	211	233	255

AQL = Protection of Aquatic Life  
HHF = Human Health Protection-Fish Consumption  
DWS = Drinking Water Supply  
GRW = Groundwater

Pollutant (µg/L)	AQL	HHF	DWS	GRW
<i>Organics</i>				
Acrolein		780	320	320
Bis-2-chloroisopropyl ether		4,360	1,400	1,400
2, chlorophenol		400	.1	.1
2,4-dichlorophenol	7	790	93	93
2,4-dinitrophenol		14,000	70	70
2,4-dimethylphenol		2,300	540	540
2,4,5-trichlorophenol		9,800	2,600	2,600
2,4,6-trichlorophenol		6.5	2	2
2-methyl-4,6-dinitrophenol		765	13	13
Ethylbenzene	320		700	700
Hexachlorocyclopentadiene	.5		50	50
Isophorone		2,600	36	36
Nitrobenzene		1,900	17	17
Phenol	100		100	300
Dichloropropene		1,700	87	87
Para(1,4)-dichlorobenzene		2,600	75	75
Other Dichlorobenzenes		2,600	600	600
1,2,4-trichlorobenzene		940	70	70
1,2,4,5-tetrachlorobenzene		2.9	2.3	2.3
pentachlorobenzene		4.1	3.5	3.5
1,1,1-trichloroethane			200	200
1,1,2-trichloroethane		42	5	5
2,4-dinitrotoluene		9	.11	.04
1,2-diphenylhydrazine		.54	.04	.04
di (2-ethylhexyl) adipate			400	400
n-nitrosodiphenylamine		16	5	5
n-nitrosopyrrolidene		91.9		
2-chloronaphthalene	4,300			
n-nitrosodi-n-propylamine		1.4		

Pollutant (µg/L)	AQL	DWS	GRW
<i>Pesticides</i>			
Demeton	.1		
Endosulfan			
chronic—	.056		
acute—	0.11		
Guthion	.01		
Malathion	.1		
Parathion	.04		
2,4-D		70	70
2,4,5-TP		50	50
Chlorpyrifos	.04		
Alachlor		2	2
Atrazine		3	3
Carbofuran		40	40
Dalapon		200	200
Dibromochloropropane		.2	.2
Dinoseb		7	7
Diquat		20	20
Endothall		100	100
Ethylene dibromide		.05	.05
Oxamyl (vydate)		200	200
Picloram		500	500
Simazine		4	4
Glyphosate		700	700

AQL = Protection of Aquatic Life  
 HHF = Human Health Protection-Fish Consumption  
 DWS = Drinking Water Supply  
 GRW = Groundwater

Pollutant ( $\mu\text{g/L}$ )	AQL	HHF	DWS	GRW
Bioaccumulative, Anthropogenic Toxics (+)				
PCBs		.000045		
.000045				
4-4' dichlorodiphenyldichloroethane (DDT)		0.00059	0.00059	0.00059
4-4' dichlorodiphenyldichloroethylene (DDE)			0.00059	0.00059
0.00059				
4-4' dichlorodiphenyldichloroethane (DDD)		0.00084	0.00083	0.00083
Endrin		.0023	2	2
Endrin aldehyde		.0023	.75	.75
Aldrin		.000079	.00013	.00013
Dieldrin		.000076	.00014	.00014
Heptachlor	.0038	.0002	0.4	0.4
Heptachlor epoxide		.00011	0.2	0.2
Methoxychlor	.03		40	40
Mirex	.001			
Toxaphene		.000073	3	3
Lindane (gamma-BHC)		.062	.2	.2
Alpha,beta,delta-BHC		.0074	.0022	.0022
Chlordane		.00048	2	2
Benzidine		.00053	.00012	.00012
2,3,7,8-tetrachlorodibenzo-p-dioxin (ng/L)*		.000014	0.000013	
0.000013				
(TCDD or dioxin)				
Pentachlorophenol**	3.2–pH 6.5 5.3–pH 7.0 8.7–pH 7.5 14.0–pH 8.0 23.0–pH 8.5	8	1	1

+ Many of these values are below current detection limits; analyses will be determined by the 17th edition of Standard Methods or the most current methods approved by the Environmental Protection Agency.

\*Units for dioxin are nanograms/liter (ng/L); 1  $\mu\text{g/L}$  = 1,000 ng/L.

\*\*Toxic impurities may be present in technical-grade pentachlorophenol; monitoring and discharge control will assure that impurities are below toxic concentrations.

HHF = Human Health Protection-Fish Consumption  
DWS = Drinking Water Supply  
GRW = Groundwater

<i>Pollutant (µg/L)</i>	<i>HHF</i>	<i>DWS</i>	<i>GRW</i>
<i>Anthropogenic Carcinogens(+)</i>			
<i>Acrylonitrile</i>	.65	.058	.058
<i>Hexachlorobenzene</i>	.00074	1	1
<i>Bis (2-chloroethyl) ether</i>	1.4	.03	.03
<i>Bis (chloromethyl) ether</i>	0.00078	.00013	.00013
<i>Hexachloroethane</i>	8.7	1.9	1.9
<i>3,3'-dichlorobenzidine</i>	0.08	.04	.04
<i>Hexachlorobutadiene</i>	50	.45	.45
<i>n-nitrosodimethylamine</i>	8	.0007	.0007

(+) Some of these values are below current detection limits; analyses will be determined by the 17th edition of Standard Methods or the most current methods approved by the Environmental Protection Agency.

<i>Pollutant (µg/L)</i>	<i>HHF</i>	<i>DWS</i>	<i>GRW</i>
<i>Volatile Organics</i>			
<i>Chlorobenzene</i>	21,000	100	100
<i>Carbon Tetrachloride</i>	5	5	5
<i>Trihalomethanes</i>		80	80
<i>Bromoform</i>	360	4.3	4.3
<i>Chlorodibromomethane</i>	34	0.41	0.41
<i>Dichlorobromomethane</i>	46	0.56	0.56
<i>Chloroform</i>	470	5.7	5.7
<i>Methyl Bromide</i>	4,000	48	48
<i>Methyl Chloride</i>	470	5	5
<i>Methylene Chloride</i>	1,600	4.7	4.7
<i>Dichlorodifluoromethane</i>	570,000		
<i>Trichlorofluoromethane</i>	860,000		
<i>1,2-dichloroethane</i>	99	5	5
<i>1,1,2,2-tetrachloroethane</i>	11	.17	.17
<i>1,1-dichloroethylene</i>	3.2	7	7
<i>1,2-trans-dichloroethylene</i>	140,000	100	100
<i>1,2-cis-dichloroethylene</i>		70	70
<i>Trichloroethylene</i>	80	5	5
<i>Tetrachloroethylene</i>	8.85	0.8	0.8
<i>Benzene</i>	71	5	5
<i>Toluene</i>	200,000	1,000	1,000
<i>Xylenes (total)</i>		10,000	10,000
<i>Vinyl chloride</i>	525	2	2
<i>Styrene</i>		100	100
<i>1,2-dichloropropane</i>	39	0.52	0.52

<i>Pollutant (Fibers/L)</i>	<i>DWS</i>	<i>GRW</i>
<i>Asbestos</i>	7,000,000	

HHF = Human Health Protection-Fish Consumption

DWS = Drinking Water Supply

GRW = Groundwater

Pollutant (µg/L)	HHF	DWS	GRW
<i>Polynuclear Aromatic Hydrocarbons</i>			
Anthracene	110,000	9,600	9,600
Fluoranthene	370	300	300
Fluorene	14,000	1,300	1,300
Pyrene	11,000	960	960
Benzo(a)pyrene	.049	0.2	0.2
other polynuclear aromatic hydrocarbons *	.049	.0044	.0044
Acenaphthene	2,700	1,200	1,200

\*This concentration is allowed for each of the following PAHs: benzo(a)anthracene, 3,4-benzofluoranthene, chrysene, dibenzo(a,h)anthracene, indeno(1,2,3-cd)pyrene and benzo(k)fluoranthene. Higher values may be allowed if natural background concentrations exceed these values.

Pollutant (µg/L)	HHF	DWS	GRW
<i>Phthalate Esters</i>			
Bis(2-ethylhexyl) phthalate	5.9	6	6
Butylbenzyl phthalate	5,200	3,000	3,000
Diethyl phthalate	120,000	23,000	23,000
Dimethyl phthalate	2,900,000	313,000	313,000
Di-n-butyl phthalate	12,000	2,700	2,700

## Health Advisory Levels

Pollutant (µg/L)	DWS	GRW
Ametryn	60	60
Baygon	3	3
Bentazon	20	20
Bis-2-chloroisopropyl ether	300	300
Bromacil	90	90
Bromochloromethane	90	90
Bromomethane	10	10
Butylate	350	350
Carbaryl	700	700
Carboxin	700	700
Chloramben	100	100
o-chlorotoluene	100	100
p-chlorotoluene	100	100
Chlorpyrifos	20	20
DCPA (dacthal)	4,000	4,000
Diazinon	0.6	0.6
Dicamba	200	200
Diisopropyl methylphosphonate	600	600
Dimethyl methylphosphonate	100	100
1,3-dinitrobenzene	1	1
Diphenamid	200	200
Diphenylamine	200	200
Disulfoton	0.3	0.3
1,4-dithiane	80	80
Diuron	10	10

DWS = Drinking Water Supply  
GRW = Groundwater

*Health Advisory Levels (continued)*

<i>Pollutant (µg/L)</i>	<i>DWS</i>	<i>GRW</i>
<i>Fenamiphos</i>	2	2
<i>Fluometron</i>	90	90
<i>Fluorotrichloromethane</i>	2,000	2,000
<i>Fonofos</i>	10	10
<i>Hexazinone</i>	200	200
<i>Malathion</i>	200	200
<i>Maleic hydrazide</i>	4,000	4,000
<i>MCPA</i>	10	10
<i>Methyl parathion</i>	2	2
<i>Metolachlor</i>	70	70
<i>Metribuzin</i>	100	100
<i>Naphthalene</i>	20	20
<i>Nitroguanidine</i>	700	700
<i>p-nitrophenol</i>	60	60
<i>Paraquat</i>	30	30
<i>Pronamide</i>	50	50
<i>Propachlor</i>	90	90
<i>Propazine</i>	10	10
<i>Propham</i>	100	100
<i>2,4,5-T</i>	70	70
<i>Tebuthiuron</i>	500	500
<i>Terbacil</i>	90	90
<i>Terbufos</i>	0.9	0.9
<i>1,1,1,2-Tetrachloroethane</i>	70	70
<i>1,2,3-trichloropropane</i>	40	40
<i>Trifluralin</i>	5	5
<i>Trinitroglycerol</i>	5	5
<i>Trinitrotoluene</i>	2	2]



Table A1			Aquatic Life Protection		Human Health Protection		DWS	IRR/LWP
POLLUTANT	CAS #	Acute		Chronic	Org.+Water	Org. Only	(µg/l)	(µg/l)
		(µg/l)	(µg/l)	(µg/l)	(µg/l)	(µg/l)		
METALS								
Aluminum (pH 6.5-9.0)	7429905	750	87					
Antimony	7440360				5.6	640	6	
Arsenic	7440382	340	150		0.018	0.14	10	100
Barium	7440393				1,000		2,000	
Beryllium	7440417						4	100
Boron	7440428							2,000
Cadmium	7440439	Table A2	Table A2				5	
Chromium (Total)	7440473						100	100
Chromium (III)	16065831	Table A2	Table A2					
Chromium (VI)	18540299	16	11					
Cobalt	7440484							1,000

Table A1			Aquatic Life Protection		Human Health Protection		DWS	IRR/LWP
POLLUTANT	CAS #	Acute (µg/l)	Chronic (µg/l)	Org.+Water (µg/l)	Org. Only (µg/l)	(µg/l)	(µg/l)	
METALS								
Copper	7440508	Table A2	Table A2	1,300		1,300	500	
Iron	7439896		1,000	300				
Lead	7439921	Table A2	Table A2			15		
Manganese	7439965			50	100			
Mercury	7439976	1.4	0.77			2		
Methylmercury	22967926				0.3 mg/kg			
Nickel	7440020	Table A2	Table A2	610	4,600			
Selenium (Total)	7782492		5	170	4,200	50		
Silver	7440224	Table A2						
Thallium	7440280			0.24	0.47	2		
Zinc	7440666	Table A2	Table A2	7,400	26,000			

Table A1			Aquatic Life Protection		Human Health Protection		DWS	IRR/LWP
POLLUTANT	CAS #	Acute (µg/l)		Chronic (µg/l)	Org.+Water (µg/l)	Org. Only (µg/l)	(µg/l)	(µg/l)
OTHER INORGANIC SUBSTANCES								
Alkalinity				20,000				
Ammonia	7664417	Table B1		Tables B2 & B3				
Asbestos	1332214				7 million fibers/L		7 million fibers/L	
Chloride	16887006	Table A2		Table A2				
Chlorine, Total Residual (Coldwater Fishery)	7782505			2				
Chlorine, Total Residual (Warmwater Fishery)	7782505	19		11				
Cyanide	57125	22		5.2	140	140	200	
E. coli Bacteria				10 CSR 20-7.031(4)(C)				
Fluoride							4,000	
Gases, Total Dissolved (percent saturation)		110%		110%				
Hydrogen Sulfide	7783064			2				

Table A1			Aquatic Life Protection		Human Health Protection		DWS	IRR/LWP
POLLUTANT	CAS #	Acute (µg/l)	Chronic (µg/l)	Org.+Water (µg/l)	Org. Only (µg/l)	(µg/l)	(µg/l)	(µg/l)
Nitrates	14797558			10,000			10,000	
Oil and Grease			10,000					
Oxygen, Dissolved	7782447	Table A3	Table A3					
pH			6.5 - 9					
Solids Dissolved and Salinity							250,000	
Solids Suspended and Turbidity			Narrative Statement					
Sulfate		Table A2	Table A2					
Temperature		10 CSR 20-7.031(4)(D)	10 CSR 20-7.031(4)(D)					
ORGANIC SUBSTANCES								
Benzenes								
Benzene	71432			2.2	51		5	
Chlorobenzene	108907			130	1,600		100	

Table A1 POLLUTANT	CAS #	Aquatic Life Protection		Human Health Protection		DWS	IRR/LWP
		Acute (µg/l)	Chronic (µg/l)	Org.+ Water (µg/l)	Org. Only (µg/l)		
1,2-Dichlorobenzene (ortho-dichlorobenzene)	95501			420	1,300	600	
1,3-Dichlorobenzene (meta-dichlorobenzene)	541731			320	960	600	
1,4-Dichlorobenzene (para-dichlorobenzene)	106467			63	190	75	
1,2,4-Trichlorobenzene	120821			35	70	70	
1,2,4,5-Tetrachlorobenzene	95943			0.97	1.1		
Pentachlorobenzene	608935			1.4	1.5		
Hexachlorobenzene	118741			0.00028	0.00029	1	
Ethylbenzene	100414			530	2,100	700	
Nitrobenzene	98953			17	690		
Styrene (Vinyl Benzene)	100425					100	
Chlorinated Hydrocarbons							
Carbon Tetrachloride (Tetrachloromethane)	56235			0.23	1.6	5	

Table A1		CAS #	Aquatic Life Protection		Human Health Protection		DWS	IRR/LWP
POLLUTANT			Acute (µg/l)	Chronic (µg/l)	Org.+Water (µg/l)	Org. Only (µg/l)		
1,2-Dichloroethane		107062			0.38	37	5	
1,1,1-Trichloroethane		71556					200	
1,1,2-Trichloroethane		79005			0.59	16	5	
1,1,2,2-Tetrachloroethane		79345			0.17	4.0		
Hexachloroethane		67721			1.4	3.3		
1,1-Dichloroethylene		75354			330	7,100	7	
cis-1,2-Dichloroethylene		156592					70	
trans-1,2-Dichloroethylene		156605			140	10,000	100	
Trichloroethylene		79016			2.5	30	5	
Tetrachloroethylene		127184			0.69	3.3	5	
1,2-Dichloropropane		78875			0.5	15	5	
1,3-Dichloropropene (Dichloropropene)		542756			0.34	21		

Table A1			Aquatic Life Protection		Human Health Protection		DWS	IRR/LWP
POLLUTANT	CAS #	Acute (µg/l)		Chronic (µg/l)	Org.+Water (µg/l)	Org. Only (µg/l)	(µg/l)	(µg/l)
Other Halogenated Hydrocarbons								
Ethylene Dibromide (1,2-Dibromoethane)	106934						0.05	
Methyl Bromide (Bromomethane)	74839				47	1,500		
Methylene Chloride (Dichloromethane)	75092				4.6	590	5.0	
Total Trihaloacetic Acids (HAA5)							60	
Total Trihalomethanes (TTHMs)							80	
Chlorodibromomethane	124481				0.4	13		
Dichlorobromomethane	75274				0.55	17		
Tribromomethane (Bromoform)	75252				4.3	140		
Trichloromethane (Chloroform)	67663				5.7	470		
Vinyl Chloride	75014				0.025	2.4	2	



Table A1			Aquatic Life Protection		Human Health Protection		DWS	IRR/LWP
POLLUTANT	CAS #	Acute (µg/l)		Chronic (µg/l)	Org.+Water (µg/l)	Org. Only (µg/l)	(µg/l)	(µg/l)
Ethers								
Bis(2-Chloroethyl) Ether	111444				0.03	0.53		
Bis(2-Chloroisopropyl) Ether	108601				1,400	65,000		
Bis(Chloromethyl) Ether	542881				0.00010	0.00029		
Miscellaneous Organics								
2,3,7,8-TCDD (Dioxin)	1746016				5.00E-09	5.1E-9	1.3 E-08	
Di(2-ethylhexyl) adipate	103231						400	
Isophorone	78591				35	960		
Polychlorinated Biphenyls (PCBs)				0.014	0.000064	0.000064	0.5	
Tributyltin (TBT)		0.46		0.072				
Nitrogen Containing Compounds								
Nitrosamines					0.0008	1.24		

Table A1	POLLUTANT	CAS #	Aquatic Life Protection		Human Health Protection		DWS	IRR/LWP
			Acute (µg/l)	Chronic (µg/l)	Org.+Water (µg/l)	Org. Only (µg/l)		
	N-Nitrosodibutylamine	924163			0.0063	0.22		(µg/l)
	N-Nitrosodiethylamine	55185			0.0008	1.24		
	N-Nitrosodimethylamine	62759			0.00069	3.0		
	N-Nitrosodiphenylamine	86306			3.3	6.0		
	N-Nitrosodi-n-propylamine	621647			0.0050	0.51		
	N-Nitrosopyrrolidine	930552			0.016	34		
	Acrylonitrile (2-propenenitrile)	107131			0.051	0.25		
	Benzidine (4,4'-diaminobiphenyl)	92875			0.000086	0.00020		
	3,3'-Dichlorobenzidine	91941			0.021	0.028		
	1,2-Diphenylhydrazine	122667			0.036	0.2		
Polynuclear Aromatic Hydrocarbons (PAHs)								
	Acenaphthene	83329			670	990		

Table A1 POLLUTANT	CAS #	Aquatic Life Protection		Human Health Protection		DWS (µg/l)	IRR/LWP (µg/l)
		Acute (µg/l)	Chronic (µg/l)	Org.+ Water (µg/l)	Org. Only (µg/l)		
Anthracene	120127			8,300	40,000		
Benzo-a-Anthracene	56553			0.0038	0.018		
Benzo-a-Pyrene	50328			0.0038	0.018	0.2	
Benzo-b-Fluoranthene	205992			0.0038	0.018		
Benzo-k-Fluoranthene	207089			0.0038	0.018		
2-Chloronaphthalene	91587			1,000	1,600		
Chrysene	218019			0.0038	0.018		
Dibenzo-a-h-Anthracene	53703			0.0038	0.018		
Fluoranthene	206440			130	140		
Fluorene	86737			1,100	5,300		
Ideno(1,2,3-cd)Pyrene	193395			0.0038	0.018		
Pyrene	129000			830	4,000		

Table A1			Aquatic Life Protection		Human Health Protection		DWS	IRR/LWP
POLLUTANT	CAS #		Acute (µg/l)	Chronic (µg/l)	Org.+ Water (µg/l)	Org. Only (µg/l)	(µg/l)	(µg/l)
Phthalate Esters								
Bis(2-Ethylhexyl) Phthalate	117817				1.2	2.2	6	
Butylbenzyl Phthalate	85687				1,500	1,900		
Diethyl Phthalate	84662				17,000	44,000		
Dimethyl Phthalate	131113				270,000	1,100,000		
Di-n-Butyl Phthalate	84742				2,000	4,500		
Phenolic Compounds								
2-Chlorophenol	95578				81	150		
2,4-Dichlorophenol	120832				77	290		
2,4-Dimethylphenol	105679				380	850		
2-Methyl-4,6-Dinitrophenol	534521				13	280		
2,4-Dinitrophenol	51285				69	5,300		

Table A1		Aquatic Life Protection		Human Health Protection		DWS	IRR/LWP
POLLUTANT	CAS #	Acute (µg/l)	Chronic (µg/l)	Org.+Water (µg/l)	Org. Only (µg/l)	(µg/l)	(µg/l)
Dinitrophenols	25550587			69	5,300		
Pentachlorophenol	87865	Table A2	Table A2	0.27	3.0	1	
Phenol	108952	10,200	2,560	10,000	860,000		
2,4,5-Trichlorophenol	95954			1,800	3,600		
2,4,6-Trichlorophenol	88062			1.4	2.4		
Toluenes							
2,4-Dinitrotoluene	121142			0.11	3.4		
Toluene	108883			1,300	15,000	1,000	
Xylenes (Total)	1330207					10,000	
PESTICIDES							
Acrolein	107028	3	3	6	9		
Alachlor	15972608					2	

Table A1 POLLUTANT	CAS #	Aquatic Life Protection		Human Health Protection		DWS (µg/l)	IRR/LWP (µg/l)
		Acute (µg/l)	Chronic (µg/l)	Org.+Water (µg/l)	Org. Only (µg/l)		
Aldrin	309002	3	1.3	0.000049	0.000050		
Atrazine	1912249					3	
Carbofuran	1563662					40	
Chlordane	57749	2.4	0.0043	0.00080	0.00081	2	
Chlorpyrifos	2921882	0.083	0.041				
Chlorophenoxy Herbicide (2,4-D)	94757			100		70	
Chlorophenoxy Herbicide (2,4,5,-TP)	93721			10		50	
Dalapon	75990					200	
Demeton	8065483		0.1				
Diazinon	333415	0.17	0.17				
1,2-Dibromo-3-chloropropane (DBCP)	96128					0.2	
4,4'- Dichlorodiphenyldichloroethyle ne (DDE)	72559			0.00022	0.00022		

Table A1		CAS #	Aquatic Life Protection		Human Health Protection		DWS	IRR/LWP
POLLUTANT			Acute (µg/l)	Chronic (µg/l)	Org.+Water (µg/l)	Org. Only (µg/l)		
4-4'-Dichlorodiphenyldichloroethane (DDD)		72548			0.00031	0.00031		(µg/l)
4-4'-Dichlorodiphenyltrichloroethane (DDT)		50293	1.1	0.001	0.00022	0.00022		
Dieldrin		60571	0.24	0.056	0.000052	0.000054		
Dinoseb		88857					7	
Diquat		85007					20	
alpha-Endosulfan (Endosulfan)		959988	0.22	0.056	62	89		
beta-Endosulfan (Endosulfan)		33213659	0.22	0.056	62	89		
Endosulfan Sulfate		1031078			62	89		
Endothall		145733					100	
Endrin		72208	0.086	0.036	0.059	0.060	2	
Endrin Aldehyde		7421934			0.29	0.30		
Glyphosate		1071836					700	

Table A1		CAS #	Aquatic Life Protection		Human Health Protection		DWS	IRR/LWP
POLLUTANT			Acute (µg/l)	Chronic (µg/l)	Org.+ Water (µg/l)	Org. Only (µg/l)		
Guthion		86500		0.01				
Heptachlor		76448	0.52	0.0038	0.000079	0.000079	0.4	
Heptachlor Epoxide		1024573	0.52	0.0038	0.000039	0.000039	0.2	
Hexachlorobutadiene		87683			0.44	18		
Hexachlorocyclopentadiene		77474			40	1,100	50	
alpha-Hexachlorocyclohexane (alpha-BHC)		319846			0.0026	0.0049		
beta-Hexachlorocyclohexane (beta-BHC)		319857			0.0091	0.017		
gamma-Hexachlorocyclohexane (gamma-BHC; Lindane)		58899	0.95		0.98	1.8	0.2	
technical- Hexachlorocyclohexane		608731			0.0123	0.0414		
Malathion		121755		0.1				
Methoxychlor		72435		0.03	100		40	
Mirex		2385855		0.001				



Table A1		Aquatic Life Protection		Human Health Protection		DWS	IRR/LWP
POLLUTANT	CAS #	Acute (µg/l)	Chronic (µg/l)	Org.+Water (µg/l)	Org. Only (µg/l)	(µg/l)	(µg/l)
Oxamyl (Vydate)	23135220					200	
Picloram	1918021					500	
Parathion	56382	0.065	0.013				
Simazine	122349					4	
Toxaphene	8001352	0.73	0.0002	0.00028	0.00028	3	
HEALTH ADVISORY LEVELS							
Aldicarb	116063					7	
Aldicarb sulfone	1646884					7	
Aldicarb sulfoxide	1646873					7	
Ametryn	834128					60	
Ammonium sulfamate	7773060					2000	
Baygon	114261					3	

Table A1	POLLUTANT	CAS #	Aquatic Life Protection		Human Health Protection		DWS	IRR/LWP
			Acute (µg/l)	Chronic (µg/l)	Org.+Water (µg/l)	Org. Only (µg/l)		
	Bentazon	25057890					200	(µg/l)
	Bis(2-Chloroisopropyl) Ether	108601					300	
	Bromacil	314409					70	
	Bromobenzene	108861					70	
	Bromochloromethane	74975					90	
	Bromomethane (Methyl Bromide)	74839					10	
	Butylate	2008415					400	
	Carbaryl	63252					700	
	Carboxin	5234684					700	
	Chloramben	133904					100	
	2-Chlorophenol	95578					40	
	ortho-Chlorotoluene	95498					100	

Table A1	POLLUTANT	CAS #	Aquatic Life Protection		Human Health Protection		DWS	IRR/LWP
			Acute (µg/l)	Chronic (µg/l)	Org.+Water (µg/l)	Org. Only (µg/l)		
	para-Chlorotoluene	106434					100	
	Chlorpyrifos	2921882					2	
	Cyanazine	21725462					1	
	DCPA (Dacthal)	1861321					70	
	Diazinon	333415					1	
	Dicamba	1918009					4,000	
	Dichlorodifluoromethane	75718					1,000	
	2,4-Dichlorophenol	120832					20	
	Diisopropyl methylphosphonate	1445756					600	
	Dimethrin	70382					2,000	
	Dimethyl methylphosphonate	756796					100	
	1,3-Dinitrobenzene	99650					1	

Table A1	CAS #	Aquatic Life Protection		Human Health Protection		DWS	IRR/LWP
		Acute (µg/l)	Chronic (µg/l)	Org.+Water (µg/l)	Org. Only (µg/l)		
POLLUTANT						(µg/l)	(µg/l)
1,4-Dioxane (para-Dioxane)	123911					200	
Diphenamid	957517					200	
Disulfoton	298044					0.7	
1,4-Dithiane	505293					80	
Diuron	330541					10	
Ethylene glycol	107211					14,000	
Fenamiphos	22224926					0.7	
Fluometuron	2164172					90	
Fonofos	944229					10	
Formaldehyde	50000					1,000	
Hexachloroethane	67721					1	
Hexazinone	51235042					400	

Table A1 POLLUTANT	CAS #	Aquatic Life Protection		Human Health Protection		DWS (µg/l)	IRR/LWP (µg/l)
		Acute (µg/l)	Chronic (µg/l)	Org.+Water (µg/l)	Org. Only (µg/l)		
HMX (octahydro-1,3,5,7-tetranitro-1,3,5,7-tetrazocine)	2691410					400	
Isophorone	78591					100	
Isopropyl methylphosphonate	1832548					700	
Malathion	121755					500	
Maleic hydrazide	123331					4,000	
MCPA (4(chloro-2-methoxyphenoxy) acetic acid)	94746					30	
Methomyl	16752775					200	
Methyl ethyl ketone	78933					4,000	
Methyl parathion	298000					1	
Metolachlor	51218452					700	
Metribuzin	21087649					70	
Naphthalene	91203					100	

Table A1 POLLUTANT	CAS #	Aquatic Life Protection		Human Health Protection		DWS (µg/l)	IRR/LWP (µg/l)
		Acute (µg/l)	Chronic (µg/l)	Org.+Water (µg/l)	Org. Only (µg/l)		
Nitroguanidine	556887					700	
para-Nitrophenol	100027					60	
Paraquat	1910425					30	
Phenol	108952					2,000	
Prometon	1610180					400	
Propazine	139402					10	
Propham	122429					100	
RDX (hexahydro-1,3,5-trinitro-1,3,5-triazine)	121824					2	
2,4,5-T (Trichlorophenoxy-acetic acid)	93765					70	
Tebuthiuron	34014181					500	
Terbacil	5902512					90	
Terbufos	13071799					0.4	

Table A1 POLLUTANT	CAS #	Aquatic Life Protection		Human Health Protection		DWS (µg/l)	IRR/LWP (µg/l)
		Acute (µg/l)	Chronic (µg/l)	Org.+Water (µg/l)	Org. Only (µg/l)		
1,1,1,2-Tetrachloroethane	630206					70	
Trichlorofluoromethane (fluorotrichloromethane)	75694					2,000	
1,3,5-Trichlorobenzene	108703					40	
1,2,3-Trichloropropane	96184					40	
Trifluralin	1582098					10	
Trinitroglycerol	55630					5	
2,4,6-Trinitrotoluene (Trinitrotoluene)	118967					2	

Table A2		
POLLUTANT	CAS #	Aquatic Life Protection
<b>METALS (µg/L) - Hardness Dependent</b>		
Cadmium	7440439	Acute = $e^{(1.0166 \cdot \ln(\text{Hardness}) - 3.062490)} * (1.136672 - (\ln(\text{Hardness}) * 0.041838))$
		Chronic = $e^{(0.7409 \cdot \ln(\text{Hardness}) - 4.719948)} * (1.101672 - (\ln(\text{Hardness}) * 0.041838))$
Chromium (III)	16065831	Acute = $e^{(0.8190 \cdot \ln(\text{Hardness}) + 3.725666)} * 0.316$
		Chronic = $e^{(0.8190 \cdot \ln(\text{Hardness}) + 0.684960)} * 0.860$
Copper	7440508	Acute = $e^{(0.9422 \cdot \ln(\text{Hardness}) - 1.700300)} * 0.960$
		Chronic = $e^{(0.8545 \cdot \ln(\text{Hardness}) - 1.702)} * 0.960$
Lead	7439921	Acute = $e^{(1.273 \cdot \ln(\text{Hardness}) - 1.460448)} * (1.46203 - (\ln(\text{Hardness}) * 0.145712))$
		Chronic = $e^{(1.273 \cdot \ln(\text{Hardness}) - 4.704797)} * (1.46203 - (\ln(\text{Hardness}) * 0.145712))$



Table A2		
POLLUTANT	CAS #	Aquatic Life Protection
<b>METALS (µg/L) - Hardness Dependent</b>		
Nickel	7440020	Acute = $e^{(0.8460 \cdot \ln(\text{Hardness}) + 2.255647)} \div 0.998$
		Chronic = $e^{(0.8460 \cdot \ln(\text{Hardness}) + 0.058978)} \div 0.997$
Silver	7440224	Acute = $e^{(1.72 \cdot \ln(\text{Hardness}) - 6.588144)} \div 0.850$
Zinc	7440666	Acute = $e^{(0.8473 \cdot \ln(\text{Hardness}) + 0.884)} \div 0.98$
		Chronic = $e^{(0.8473 \cdot \ln(\text{Hardness}) + 0.884)} \div 0.98$
<b>OTHER POLLUTANTS (mg/L) - Hardness Dependent</b>		
Chloride	16887006	Acute = $287.8 \cdot (\text{Hardness})^{0.205797} \cdot (\text{Sulfate})^{-0.07452}$
		Chronic = $177.87 \cdot (\text{Hardness})^{0.205797} \cdot (\text{Sulfate})^{-0.07452}$

Table A2																						
POLLUTANT	CAS #	Aquatic Life Protection																				
OTHER POLLUTANTS (mg/L) - Hardness Dependent																						
Sulfate		<table><tr><td></td><td colspan="3">Chloride (Cl-), mg/L</td></tr><tr><td>Hardness (H), mg/L</td><td>Cl- &lt; 5</td><td>5 ≤ Cl- &lt; 25</td><td>25 ≤ Cl- ≤ 500</td></tr><tr><td>H &lt; 100</td><td>500</td><td>500</td><td>500</td></tr><tr><td>100 ≤ H ≤ 500</td><td>500</td><td>S1</td><td>S2</td></tr><tr><td>H &gt; 500</td><td>500</td><td>2,000</td><td>2,000</td></tr></table>		Chloride (Cl-), mg/L			Hardness (H), mg/L	Cl- < 5	5 ≤ Cl- < 25	25 ≤ Cl- ≤ 500	H < 100	500	500	500	100 ≤ H ≤ 500	500	S1	S2	H > 500	500	2,000	2,000
		Chloride (Cl-), mg/L																				
	Hardness (H), mg/L	Cl- < 5	5 ≤ Cl- < 25	25 ≤ Cl- ≤ 500																		
	H < 100	500	500	500																		
	100 ≤ H ≤ 500	500	S1	S2																		
H > 500	500	2,000	2,000																			
		$S1 = [-57.478 + 5.79 (\text{hardness}) + 54.163 (\text{chloride})] * 0.65$																				
		$S2 = [1276.7 + 5.508 (\text{hardness}) - 1.457 (\text{chloride})] * 0.65$																				

Table A2		
POLLUTANT	CAS #	Aquatic Life Protection
OTHER POLLUTANTS (µg/L) - Equation Dependent		
Pentachlorophenol	87865	Acute = $e^{((1.005 * (pH)) - 4.869)}$
		Chronic = $e^{((1.005 * (pH)) - 5.134)}$

Table A3

## POLLUTANT

## DISSOLVED OXYGEN (mg/L)

	Cold-Water Fishery		Warm-Water & Cool-Water Fishery	
	Early Life Stages	Other Life Stages	Early Life Stages	Other Life Stages
30 Day Mean	NA	6.5	NA	5.5
7 Day Mean	9.5 <sup>1</sup> (6.5) <sup>2</sup>	NA	6.0	NA
7 Day Mean Minimum	NA	5.0	NA	4.0
1 Day Minimum <sup>3</sup>	8.0 <sup>1</sup> (5.0) <sup>2</sup>	4.0	5.0	3.0

NA - Not Applicable

1 - Applies to waters that provide a habitat which supports natural reproduction of a salmonid (trout) population. These waters also are capable of maintaining year-round populations of a variety of other coldwater fish and associated vertebrate and invertebrate organisms.

2 - Applies to waters that provide, or could provide, a habitat capable of maintaining year-round populations of a variety of coldwater fish and associated vertebrate and invertebrate organisms or which support the seasonal migration of salmonids. These waters do not support natural reproduction of salmonid populations due to limitations of flow, substrate composition, or other habitat conditions, but salmonid populations may be maintained year-round if periodically stocked.

3 - All minima should be considered as instantaneous concentrations to be achieved at all times.

Table C  
Waters Designated for Cold-Water Fishery

Water Body	Miles/Acres	From	To	County(ies)
Barren Fork	2.0	Mouth	20,31N,4W	Shannon
Bee Creek	1.0	Mouth	Hwy. 65	Taney
Bender Creek	0.7	Mouth	10,31N,9W	Texas
Bennett Springs Creek	[2.0] 1.6	Mouth	Bennett Springs	[Laclede/Dallas
Blue Springs Creek	[4.0] 4.2	Mouth	2,39N,3W	Crawford
Bryant Creek	1.0	3,23N,12W	34,24N,12W	Ozark
Bryant Creek	6.0	19,27N,14W	8,27N,15W	Douglas
Buffalo Creek	10.0	State line	5,23N,33W	McDonald
Bull Creek	5.0	Mouth	34,24N,21W	Taney
Bull Shoals Lake	9,000.0 ac.	21/34,20N,15W	—	Ozark
Capps Creek	[4.0] 5.0	Mouth	17,25N,28W	Newton
Cedar Creek	1.0	21,26N,32W	28,26N,32W	Newton
Center Creek	3.0	24,27N,29W	17,27N,28W	Lawrence
[Chesapeake Creek]	[3.0]	Mouth	29,28N,25W	Lawrence
Chesapeake Branch	3.2			
Crane Creek	15.0	8,25N,23W	24,26N,25W	Stone-Lawrence
Current River	19.0	24,31N,6W	Montauk Spring	Shannon-Dent
Dogwood Creek	2.3	Mouth	State line	Stone
Dry Creek	[4.0] 5.0	Mouth	14,37N,3W	Crawford
Eleven Point River	33.5	State line	36,25N,4W	Oregon
Flat Creek	3.0	9,23N,27W	21,23N,27W	Barry
Goose Creek	4.0	Mouth	10,28N,25W	Lawrence
Greer Spring Branch	[1.0] 1.3	Mouth	36,25N,4W	Oregon
Hickory Creek	4.5	13,25N,31W	28,25N,31W	Newton
[Hobbs Hollow]	2.7	Mouth	State line	Stone
Trib. to L. Indian Cr.				
Horse Creek	2.2	Mouth	23,35N,8W	Dent
Hunter Creek	5.0	[22,26N,15W] Mouth	[20,26N,14W] 22,26N,15W	Douglas
Hurricane Creek	1.5	Mouth	30,24N,12W	Ozark
Hurricane Creek	3.2	Mouth	22,25N,3W	Oregon
[Indian Creek]	1.4	Mouth	17,21N,23W	Stone
Little Indian Creek				
Indian Creek	20.0	Mouth	36,39N,01W	Franklin-Washington
Johnson Creek	3.0	Mouth	36,29N,26W	Lawrence
Joyce Creek	1.0	17,24N,28W	16,24N,28W	Barry
L. Flat Creek	3.5	Mouth	25,25N,27W	Barry
L. Piney Creek	15.0	25,37N,9W	4,35N,8W	Phelps
L. Piney Creek	4.0	04,35N,08W	21,35N,08W	Phelps
L. Sinking Creek	2.2	Mouth	[33,32N,4W] 33,32N,3W	[Dent/Shannon-Dent
Lake Taneycomo	1,730.0 ac.	8,23N,20W	—	Taney
Lyman Creek	1.0	Mouth	30,40N,3W	Crawford
Maramec Spring Branch	1.0	Mouth	1,37N,6W	Phelps
Meramec River	10.0	22,38N,5W	Hwy. 8	Crawford
Mill Creek	1.5	Mouth	9,36N,18W	Dallas

Table C  
Waters Designated for Cold-Water Fishery

Water Body	Miles/Acres	From	To	County(ies)
Mill Creek	5.0	29,37N,9W	Yelton Spring	Phelps
Mill Creek	1.5	Mouth	11,40N,8W	Maries
<i>[N. Fork White River]</i>	23.0	09,22N,12W	34,25N,11W	Ozark
<b>North Fork River</b>				
Niangua River	6.0	11,35N,18W	Bennett Sp. Creek	Dallas
Roaring River	7.0	Mouth	34,22N,27W	Barry
Roark Creek	<i>[3.0]</i>	Mouth	36,23N,22W	Taney
	2.7			
Roubidoux Creek	4.0	Mouth	25,36N,12W	Pulaski
S. Indian Creek	<i>[9.0]</i>	24,24N,31W	1,23N,30W	Newton
	8.7			
<i>[Schafer Spring Creek]</i>	2.0	Mouth	20,32N,6W	Dent
<b>Trib. to Current River</b>				
Shoal Creek	1.0	Mouth	18,41N,17W	Morgan-Morgan
Shoal Creek	<i>[7.0]</i>	<i>[09,25N,29W]</i>	<i>[16,22N,21W]</i>	Newton
	0.5	9,25N,29W	15,25N,29W	
Spring Branch	1.0	Mouth	18,41N,17W	Morgan
Spring Creek	6.5	Mouth	31,35N,9W	Phelps
Spring Creek	2.5	Mouth	4,41N,2W	Franklin
Spring Creek	5.5	Mouth	12,26N,24W	Stone
Spring Creek	6.0	Mouth	06,24N,13W	Douglas-Ozark
Spring Creek	2.5	Mouth	26,25N,11W	Douglas
Spring Creek	<i>[5.0]</i>	Mouth	14,23N,11W	Ozark
	5.2			
Spring Creek	4.0	Mouth	30,25N,4W	Oregon
Spring River	11.2	13,27N,27W	20,26N,26W	Lawrence
Stone Mill Spring Branch	0.2	Mouth	Spring	Pulaski
Terrell Creek	<i>[2.0]</i>	Mouth	2,27N,23W	Christian
	1.0			
Tory Creek	2.5	Mouth	27,26N,22W	Stone-Christian
Turkey Creek	2.0	Mouth	16,22N,21W	Taney
Turkey Creek	1.0	Mouth	17,23N,15W	Ozark
Turnback Creek	14.0	35,30N,26W	24,28N,25W	Dade-Lawrence
Warm Fork Spring River	3.0	6,22N,5W	30,23N,5W	Oregon
Whittenburg Creek	2.5	Mouth	Hwy. 8	Crawford
Williams Creek	1.0	Mouth	28,28N,27W	Lawrence
<i>[Woods Fork Bull Creek]</i>	1.0	15,25N,21W	15,25N,21W	Christian
<b>Woods Fork</b>				
Yadkin Creek	3.0	Mouth	9,37N,4W	Crawford
Yankee Branch	1.0	Mouth	10,36N,4W	Crawford

Table G-Lake Classifications and Use Designations

NOTE: Fishing, Swimming and livestock watering may not be allowed in some lakes by the local management authorities. The use designations refer only to the protection of water quality for those potential uses.

WATER BODY	CLASS	ACRES	LOCATION	COUNTY(IES)	LWW	AQL	CDF	WBC	SCR	DWS	IND
100 K Statewide Extent	L3	0.0	Statewide	Statewide	X	X		B	X		
34 Corner Blue Hole	L3	9.0	35,25N,17E	Mississippi	X	X		B			
Adrian Reservoir	L1	45.0	[03,41N,31W] NWNE 3,41N,31W	Bates	X	X		B		X	
Agate Lake	L3	210.7	[13,60N,06W] 13,60N,6W	Lewis	X	X		A	X		
Amarugia Lake	L3	39.0	10/11,43N,32W	Cass	X	X		B	X		
Anderson's Whippoorwill Farm Lake	L3	30.0	SW SE 28,28N,11E	Stoddard	X	X		B			
[Anthonies Mill Lake] Lake Ashely	L3	91.0	[SW SW 19,39N,01W] SWSW 19,39N1W	Washington	X	X		B	X		
Antitini Lake	L3	2.0	NE NE 3,48N,12W	Boone	X	X		B			
Apollo Lake	L3	15.0	21,36N,05E	St. Francois	X	X		B	X		
Appleton City Lake	L1	35.0	12,39N,29W	Bates	X	X		B		X	
Archie Lakes	L1	7.3	SESE28,43N,31W	Cass	X	X		B		X	
Armstrong Lake	L1	8.0	NE NE 28,52N,16W	Howard	X	X		B		X	
Athens State Park Lake	L3	8.0	[30,67N,07W] NENW 30,67N,7W	Clark	X	X		A	X		
Atkinson Lake	L3	434.0	NW SE06,37N,28W	St. Clair/Vernon	X	X		A	X		
Atlanta City Lake	L1	17.0	SE SW29,59N,14W	Macon	X	X		B		X	
Austin Community Lake	L3	21.0	30,29N,11W	Texas	X	X		A	X		
Baha Trail Lake	L3	16.0	05,39N,01E	Washington	X	X		B	X		
Baring Country Club Lake	L1	[81.0] 77.0	[SE26,63N,12W] SESE 26,63N,12W	Knox	X	X		A	X	X	
Bass Lake	L3	29.0	13,47N,08W	Callaway	X	X		A	X		
Bean Lake	L3	420.0	12,13,14,23, 24, 54N,37W	Platte	X	X		B	X		
[Bear Creek Watershed Lake] Bear Creek Watershed Lake F-1	L3	26.7	[6,63N,09W] NENE 6,63N,09W	Clark	X	X		B	X		
Bear Creek Watershed Lake X-5	L3	28.0	SESE 15,64N,10W	Scotland	X	X		B			
Beaver Lake	L3	14.0	22,25N,04E	Butler	X	X		A			
Bee Run Lake No. 1	L3	6.0	NENW 26,38N,4E	St. Francois	X	X		B			
Bee Run Lake No. 2	L3	4.0	SESE 23,38N,4E	St. Francois	X	X		B			
Bee Run Lake No. 3	L3	6.0	SWSW 24,38N,4E	St. Francois	X	X		B			
Bee Tree Lake	L3	10.0	03,42N,06E	St. Louis	X	X		B	X		
Belcher Branch Lake	L3	42.0	[08/17,55N,34W] NENE 17,55N,34W	Buchanan	X	X		B	X		
Belle City Lake	L3	6.0	20,41N,07W	Maries	X	X		B			
Ben Branch Lake	L3	37.0	15/14,44N,08W	Osage	X	X		B	X		
Berndt Lake	L1	21.0	NE SW30,66N,23W	Mercer	X	X		B		X	
Bevier Lake	L3	5.0	S SE,14,57N,15W	Macon	X	X		B			
Big Buffalo C.A. Lakes	L3	7.9	2,12,41N,20W	Benton	X	X		B			
Big Lake	L3	666.0	18&19,30,61N,39W	Holt	X	X		A	X		
Big Oak Tree S.P. Lake	L3	33.0	14,23N,16E	Mississippi	X	X		B			
Big Soldier Lake	L3	5.0	36,50N,19W	Saline	X	X		B	X		
Bilby Ranch Lake	L3	95.0	13/24,64N,38W	Nodaway	X	X		B	X		
Binder Lake	L3	127.0	SW SE36,45N,13W	Cole	X	X		B	X		
Blind Pony Lake	L3	96.0	NW SE18,49N,22W	Saline	X	X		B	X		
Bloodland Lake (Ft. Wood)	L3	38.1	04,34N,11W	Pulaski	X	X		B	X		
Blue Mountain Lake	L1	14.0	NW SE,09,33N,5E	Madison	X	X		B		X	
Blue Springs Lake	L3	642.0	33,49N,31W	Jackson	X	X		A	X		
Blues Pond	L3	10.0	09,37N,08W	Phelps	X	X		B	X		
[Bluestem Lake] Reed Area No. 10 Lake	L3	13.0	[22,47N,31W] SENE 22,47N,31W	Jackson	X	X		B	X		
Bo Co Mo Lake	L3	140.0	[NW NE10,49N,13W] NWNE 10,49N,13W	Boone	X	X		B	X		
[Bodarc Lake] Reed Area No. 9 Lake	L3	13.0	[23,47N,31W] SWNE 23,47N,31W	Jackson	X	X		B	X		
Boggs Lake	L3	32.0	21-28,44N,05W	Gasconade	X	X		B	X		
Bonne Aqua Lake	L3	6.0	SE NE 26,38N,04E	St. Francois	X	X		B			

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Protection of Warm Water Aquatic Life and Human  
Health-Fish Consumption  
CDF-Cold Water Fishery

WBC-Whole Body Contact Recreation  
SCR-Secondary Contact Recreation  
DWS-Drinking Water Supply  
IND-Industrial

WATER BODY	CLASS	ACRES	LOCATION	COUNTY(IES)	LWW	AQL	CDF	WBC	SCR	DWS	IND
Bonne Terre City Lake	L3	10.0	[SUR 467,37N,04E] LG 467,37N,4E	St. Francois	X	X		B			
Boulder Lake	L3	13.0	SWNW 12,60N,6W	Lewis	X	X		B	X		
[Bowling Green Lake - Old] Old Lake	L1	[7.0] 29.0	[NE NE30,53N,02W] NENE 30,53N,2W	Pike	X	X		B			X
Bowling Green Reservoir	L1	41.0	W NW29,53N,02W	Pike	X	X		B	X	X	
Brays Lake	L3	162.0	NE NW35,37N,08W	Phelps	X	X		B	X		
Breckenridge Lake	L1	13.0	NE SW3,57N,26W	Caldwell	X	X		B	X	X	
Brookfield Lake	L1	120.0	SE SE33,58N,19W	Linn	X	X		B		X	
Browning Lake	L3	120.0	22,25,26,27,3N,22E	Buchanan	X	X		B	X		
Bucklin Lake	L1	17.0	11,57N,18W	Linn	X	X		B			X
Buffalo Bill Lake	L3	45.0	28,58N,31W	DeKalb	X	X		B	X		
Bull Shoals Lake	L2	9,000.0	21/34,20N,15W	Ozark	X	X	X	A	X		
Burlington Lake	L3	21.0	34,57N,30W	Clinton	X	X		B			
[Busch W.A.- Kraut Run Lake]	L3	164.0	[SUR 56 (NW NE23,46N,02E)]	St. Charles	X	X		B			
Kraut Run Lake			LG 56,46N,2E								
[Busch W.A. No. 35 Lake]	L3	[51.0] 50.0	[SUR 1669 (NE NE30,46N,03E)]	St. Charles	X	X		B			
Lake No. 35			LG 1669,46N,3E								
Busch W.A. No. 37 Lake	L3	30.0	SWSW 27,46N,2E	St. Charles	X	X		B	X		
Bushwacker Lake	L3	148.0	26,34N,32W	Vernon	X	X		B	X		
Butler Lake	L1	71.0	NW NE14,40N,32W	Bates	X	X		B			X
Butterfly Lake	L3	65.0	NW NE34,36N,07E	Ste. Genevieve	X	X		B			
C & A Lake	L3	39.0	25,51N,09W	Audrain	X	X		B			
Callaway Lake	L3	135.0	06,45N,02E	St. Charles	X	X		A	X		
Cameron Lake #1	L1	25.0	SW SW10,57N,30W	DeKalb	X	X		B	X	X	
Cameron Lake #2	L1	31.0	SW SW10,57N,30W	DeKalb	X	X		B	X	X	
Cameron Lake #3	L1	92.0	NW NE09,57N,30W	DeKalb	X	X		B	X	X	
Cameron Lake #4 (Grindstone Reservoir)	L1	173.0	NE NW 08,57N,30W	DeKalb	X	X		B		X	
Camp Solidarity Lake	L3	10.0	24,43N,02E	Franklin	X	X		B	X		
Carrollton Recreation Lake	L3	61.0	SE NW07,52N,23W	Carroll	X	X		B	X		
Catclaw Lake	L3	42.0	14,47N,31W	Jackson	X	X		B	X		
Cedar Hill Lake No. 2	L3	11.2	SWSW 35,42N,3E	Jefferson	X	X		B			
Cedar Hill Lake No. 3	L3	1.6	SWSE 35,42N,3E	Jefferson	X	X		B			
[Cedar Hill Lakes]	L3	[22.6] 11.0	[35,42N,03E]	Jefferson	X	X		A	X		
Cedar Hill Lake No. 1			NESW 35,42N,3E								
Cedar Lake	L3	21.0	35,48N,13W	Boone	X	X		A	X		
Cedar Lake	L3	45.0	SE SE 21,37N,05E	St. Francois	X	X		A	X		
Charity Lake	L3	9.0	NW SE 1,65N,41W	Atchison	X	X		B	X		
City Lake #1 (Perry)	L1	16.0	NW NW34,54N,07W	Ralls	X	X		B		X	
City Lake #2 (Perry)	L1	7.0	NW34,54N,07W	Ralls	X	X		B		X	
[City Lake Harrisonville]	L1	[28.0] 21.0	[34,45N,31W]	Cass	X	X		B	X	X	
City Lake			SESW 34,45N,31W								
Clarence Cannon Memorial Watershed Structure No. 1 Reservoir	L3	23.2	NENE 28,51N,1E	Lincoln	X	X		B			
[Clarence Lake #1] Old Lake	L1	20.0	[15,57N,12W] NENW 15,57N,12W	Shelby	X	X		B	X	X	
Clarence Lake #2	L1	[31.0] 34.0	[15,57N,12W] NWNW 15,57N,12W	Shelby	X	X		B	X	X	
Clear Lake	L3	12.5	NWSE 36 39N,4E	Jefferson	X	X		A			
Clearwater Lake	L2	1,635.0	[NW NE06,28N,03E] NWNW 6,28N,3E	[Wayne/Reynolds] Wayne	X	X		A	X		
Cleveland Reservoir	L1	10.0	29,45N,33W	Cass	X	X		B		X	
Clover Dell Park Lake	L3	10.0	13,45N,22W	Pettis	X	X		B	X		
Cole Lake	L3	40.0	SE10,38N,04E	Jefferson	X	X		A	X		
Conner O. Fewell C.A. Lakes	L3	14.0	32,43N,25W	Henry	X	X		B	X		
Cool Valley Lake	L3	19.0	[09,40N,02E]	Franklin	X	X		B	X		
Cooley Lake	L3	380.0	SWNE 9,40N,2E	Clay	X	X		B			
Coot Lake	L3	[20.0] 22.0	[22,47N,31W]	Jackson	X	X		B	X		

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WATER BODY	CLASS	ACRES	LOCATION	COUNTY(IES)	LWW	AQL	CDF	WBC	SCR	DWS	IND
			SWSW 22,47N,31W								
Cosmo-Bethel Lake	L3	6.0	NW36,48N,13W	Boone	X	X		B			
Cottontail Lake	L3	22.0	14,47N,31W	Jackson	X	X		B	X		
Council Bluff Lake	L3	423.0	[23,35N,01E]	Iron	X	X		A	X		
			NWSW 23,35N,1E								
Crane Lake	L3	109.0	W33,32N,04E	Iron	X	X		B	X		
Creighton Lake	L1	18.0	NW SE,14,43N,29W	Cass	X	X		B		X	
Crescent Lake	L3	8.0	NE 02,41N,01W	Franklin	X	X		B	X		
Creve Coeur Lake	L3	327.0	20,46N,05E	St. Louis	X	X		B	X		
[Crowder St. Park Lake]	L3	18.0	[12,61N,25W]	Grundy	X	X		A			
Crowder Lake			SENW 12,61N,25W								
Crystal Lake	L3	122.0	NW SW32,53N,29W	Ray	X	X		A	X		X
Cut-off Lake	L3	148.5	01,12,57N,36W	Buchanan	X	X		B			
Cut-off Lake	L3	674.0	26,27,34,35,53N,19W	Chariton	X	X		B			
Cypress Lake	L3	88.0	SESE 17,24N,9E	Stoddard	X	X		B	X		
D.C. Rogers Lake	L1	195.0	NW NW10,50N,16W	Howard	X	X		B	X	X	
Davis Lake	L3	44.0	NE NW15,50N,16W	Howard	X	X		B			
Dearborn Reservoir	L1	7.0	[31,55N,34W]	Buchanan	X	X		B	X	X	
			SWNW 31,55N,34W								
Deer Ridge Community Lake	L3	39.0	[18,62N,08W]	Lewis	X	X		B	X		
			NENW 18,62N,8W								
Deer Run Lake	L3	0.0	19,34N,7E	Madison	X	X		B			
Dexter City Lake	L3	11.0	22,25N,10E	Stoddard	X	X		B			
[DiSalvo Lake]	L3	210.0	SW NE19,35N,04E	St. Francois	X	X		B	X		
Hemite Lake											
Downing Reservoir	L1	22.9	[SW SE17,66N,13W]	Schuyler	X	X		B		X	
			SWSE 17,66N,13W								
Drexel City Reservoir South	L1	51.0	7,42N,33W	Bates	X	X		B		X	
Drexel Lake	L1	28.0	6,42N,33W	Bates	X	X		B		X	
Duck Creek	L3	1,730.0	31,28N,09E: 5, 27N, 9E	Wayne	X	X		B	X		
Eagle Sky Lake	L3	62.0	NW NW35,30N,04E	Wayne	X	X		B	X		
Eagleville Lake	L1	40.0	33,66N,27W	Harrison	X	X		A	X	X	
East Arrowhead Lake	L3	55.0	SE SE18,23N,08W	Howell	X	X	X	A			
[Edina Lake]	L1	[9.0] 10.0	[07,62N,11W]	Knox	X	X		B	X	X	
Edina Reservoir Section 7			SWSE 7,62N,12W								
Edina Reservoir	L1	51.0	[12,62N,11W]	Knox	X	X		B	X	X	
			NESE 12,62N,12W								
Edwin A Pape Lake	L1	272.5	20,48N,24W	Lafayette	X	X		B	X	X	
Ella Ewing Community Lake	L3	[15.0] 11.0	21,64N,10W	Scotland	X	X		A	X		
Elmwood City Lake	L1	197.0	NW 35,63N,20W	Sullivan	X	X		B		X	
Elsie Lake	L3	17.0	30,37N,02E	Washington	X	X		A	X		
Ethel Lake	L1	23.0	NE NW36,59N,17W	Macon	X	X		B		X	
Ewing Lake	L1	[43.0] 36.0	[06,60N,07W]	Lewis	X	X		B	X	X	
			SESE 6,60N,7W								
Fawn Lake	L3	26.0	13,43N,02W	Franklin	X	X		B	X		
Fellows Lake	L1	800.0	NW NE22,30N,21W	Greene	X	X		A	X	X	
Finger Lakes	L3	118.0	19,30,31,50N,12W,24,25,36, 50N13W	Boone	X	X		A			
Flat Rock Lake	L3	17.2	NWNE 31,41N,3E	Jefferson	X	X		B			
Flight Lake	L3	100.0	26,36N,32W	Vernon	X	X		B			
Forest Lake	L1	580.0	SE SW14,62N,16W	Adair	X	X		A		X	
Fountain Grove Lakes	L3	1,366.3	35,57N,22W	Linn	X	X		B	X		
Fourche Lake	L3	49.0	[22,23N,01W]	Ripley	X	X		A	X		
			22,23N,1W								
Fox Valley Lake	L3	89.0	[27,66N,08W]	Clark	X	X		B	X		
			NWSE 27,66N,8W								
Foxboro Lake	L3	22.0	[14,42N,04W]	Franklin	X	X		B	X		
			SWNE 14,42N,4W								
Fredricktown City Lake	L1	80.0	06,33N,07E	Madison	X	X		B		X	
Freeman Lake	L1	13.0	SW SW18,44N,32W	Cass	X	X		B		X	
Frisco Lake	L3	5.0	SE SE 02,37N,08W	Phelps	X	X		B			
Garden City Lake	L1	26.0	31,44N,29W	Cass	X	X		B		X	
Garden City New Lake	L1	39.0	NW18,43N,29W	Cass	X	X		B		X	

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WATER BODY	CLASS	ACRES	LOCATION	COUNTY(IES)	LWW	AQL	CDF	WBC	SCR	DWS	IND
Garfield Lake	L3	12.0	NWNE 36,51N,9W	Audrain	X	X		B			
Gerald City Lake	L3	5.0	[12,42N,04W] SESW 12,42N,4W	Franklin	X	X		B			
Giessing Lake	L3	4.0	LG 2969,35N,5E	St. Francois	X	X		B	X		
Glover Spring Lake	L3	23.0	13,47N,09W	Callaway	X	X		B			
Goff Spring Lake	L3	13.0	SENE 23,38N,4E	St. Francois	X	X		B			
Golden Eagle Lake	L3	105.0	SE SW16,48N,04W	Montgomery	X	X		B			
Goose Creek Lake	L3	[308.3] 335.0	NW NW25,38N,06E	[Ste. Genevieve/St. Francois]	X	X		A	X		
Gopher Lake	L3	38.0	23,47N,31W	Ste. Genevieve Jackson	X	X		B	X		
Gower Lake	L1	11.0	10,55N,33W	Clinton	X	X		B			X
Granite Lake	L3	8.0	SWNW 12,60N,6W	Lewis	X	X		B	X		
Green City Lake	L1	57.0	SE NE16,63N,18W	Sullivan	X	X		B			X
Green City Lake (Old)	L1	60.0	SE18,63N,18W	Sullivan	X	X		A			X
Hager Lake	L3	9.0	SUR 2969,35N,05E	St. Francois	X	X		B			
Hamilton Lake	L1	80.0	SW SW15,57N,28W	Caldwell	X	X		B	X		X
Harmony Mission Lake	L3	96.0	15,38N,32W	Bates	X	X		B	X		
Harrison County Lake	L1	280.0	17/30,65N,28W	Harrison	X	X		B			X
Harrisonville City Lake	L1	419.0	[SW SW26,46N,31W] SWSW 26,46N,31W	Cass	X	X		B	X		X
Hazel Creek Lake	L1	453.0	SW SW31,64N,15W	Adair	X	X		B			X
Hazel Hill Lake	L3	62.0	27,47N,26W	Johnson	X	X		B	X		
Helvey Park Lake	L1	11.0	26,53N,33W	Clay	X	X		B			X
Henke Lake	L3	70.0	[SE SE20,46N,09W] SESE 20,46N,9W	Callaway	X	X		B			
Henry Sever Lake	L3	158.0	[NE NE14,60N,10W] NENE 14,60N,10W	Knox	X	X		A	X		
Hermit Hollow Lake	L3	8.0	29,44N,02E	Franklin	X	X		B	X		
Hi Point Lake	L3	[3.0] 2.0	[24,39N,01E] 25,39N,1E	Washington	X	X		B			
Higbee Lake	L1	13.0	SE SW09,52N,14W	Randolph	X	X		B			X
Higginsville Reservoir (North)	L1	47.0	NE SW04,49N,25W	Lafayette	X	X		B	X		X
Higginsville Reservoir (South)	L1	147.1	SW NE09,49N,25W	Lafayette	X	X		B	X		X
Holden City Lake	L1	290.2	29,46N,28W	Johnson	X	X		B	X		X
[Holden Lake]	L3	11.0	12,45N,28W	Johnson	X	X		B	X		
No. 203 Reservoir											
[Holden Lake]	L3	11.0	07,45N,27W	Johnson	X	X		B			
Holden Reservoir East											
Holiday Acres Lake	L3	206.1	SE SW17,55N,14W	Randolph	X	X		B			
Horseshoe Lake	L3	56.0	15,56N,36W	Buchanan	X	X		B			
Hough Park Lake	L3	10.0	19,44N,11W	Cole	X	X		B			
Houston Lake	L3	16.0	NW 33,51N,33W	Platte	X	X		A	X		
Howell Mill Lakes	L3	97.0	17,36N,01E	Washington	X	X		A	X		
HS Truman Lake	L2	55,600.0	[07,40N,22W] 7,40N,22W	Benton	X	X		A	X		X
Hunnewell Lake	L3	228.0	NW SW25,57N,09W	Shelby	X	X		B	X		
Hurdland Severs Lake	L3	13.0	1,61N,13W	Knox	X	X		A	X		
Incline Village Lake	L3	171.0	NWSW 6,47N,1E	St. Charles	X	X		B	X		
Indian Creek Community Lake	L3	185.0	15/27,59N,25W	Livingston	X	X		B	X		
Indian Lake	L3	279.0	22,15,23,39N,05W	Crawford	X	X		A	X		
Iron Mtn Lake	L3	79.0	SE SW32,35N,04E	St. Francois	X	X		B	X		
Izaak Walton Lake	L3	11.0	32,36N,31W	Vernon	X	X		B	X		
Jackass Bend	L3	200.0	32,28,21-19,51N,29W	[Ray/Jackson] Jackson	X	X		B	X		X
Jackrabbit Lake	L3	25.0	15,47N,31W	Jackson	X	X		B	X		
Jamesport City Lake	L1	16.0	22,60N,26W	Daviess	X	X		B			X
Jamesport Community Lake	L1	27.0	NE 20,60N,26W	Daviess	X	X		A	X		X
Jasper Lake	L3	43.0	12,60N,06W	Lewis	X	X		A	X		
Jaycee Park Lake	L3	8.0	17,44N,12W	Cole	X	X		B			
Jerry P. Combs Lake	L3	149.0	SE 34,19N,10E	Dunklin	X	X		B	X		
Jo Lee Lake	L3	8.0	NESE 19,36N,5E	St. Francois	X	X		B	X		

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Junges Lake	L3	37.0	10,41N,21W	Benton	X	X		A	X		
Kahrs-Boger Park Lake	L3	2.0	15,44N,20W	Pettis	X	X		B	X		
Kellogg Lake	L3	22.0	34,29N,31W	Jasper	X	X		A	X		
King City Lake (South)	L1	29.0	SW SW34,61N,32W	Gentry	X	X		B		X	
King City New Reservoir	L1	25.4	28,61N,32W	Gentry	X	X		B		X	
King City Old Reservoir	L1	12.0	SW NE28,61N,32W	Gentry	X	X		B		X	
King Lake	L3	204.0	13,60N,32W	DeKalb	X	X		A	X	X	
Kiwanis Lake	L3	4.0	[SW23,51N,9W] SWSW 23,51N,9W	Audrain	X	X		B			
Klontz Lake	L3	14.0	02,39N,04W	Crawford	X	X		A	X		
[Knob Noster St. Park Lakes] Clear Fork Lake	L3	[24.0] 16.0	[29/30,46N,24W] 30,46N,24W	Johnson	X	X		B			
[L. Prairie Comm. Lake] L. Prairie Lake	L3	95.0	[SE SE21,38N,7W] SESE 21,38N,7W	Phelps	X	X		B	X		
[La Plata Lake - New] La Plata City Reservoir East	L1	[81.0] 79.0	[NW 14,60N,14W] NWNE 14,60N,14W	Macon	X	X		B		X	
[La Plata Lake - Old] Laplata Lake	L1	22.0	[09,60N,14W] SENW 9,60N,14W	Macon	X	X		B		X	
[Labelle Lake #1] New La Belle Lake	L1	18.0	16,61N,09W	Lewis	X	X		B	X	X	
[Labelle Lake #2] Bellevue Lake	L1	98.0	[NW NE16,61N,09W] NWNW 16,61N,9W	Lewis	X	X		B	X	X	
Lac Benet Lake	L3	7.0	SWSE 20,37N,4E	St. Francois	X	X		A	X		
Lac Bergerac	L3	6.0	SENW 19,37N,4E	St. Francois	X	X		A	X		
Lac Bourbon	L3	6.0	SWNE 19,37N,4E	St. Francois	X	X		A	X		
Lac Calista	L3	5.0	NENW 28,37N,4E	St. Francois	X	X		A	X		
Lac Carmel	L3	54.0	SWNE 18,37N,4E	St. Francois	X	X		A	X		
Lac Catalina	L3	5.0	NWSW 19,37N,4E	St. Francois	X	X		A	X		
Lac Darcie	L3	4.0	SENW 19,37N,4E	St. Francois	X	X		A	X		
Lac Lafitte	L3	34.0	NESW 28,37N,4E	St. Francois	X	X		A	X		
Lac Marseilles	L3	44.0	NWSW 29,37N,4E	St. Francois	X	X		A	X		
Lac Michel	L3	7.0	NESE 19,37N,4E	St. Francois	X	X		A	X		
Lac Renee	L3	4.0	NWNW 20,37N,4E	St. Francois	X	X		A	X		
Lac Shayne	L3	13.0	NESE 25,37N,3E	Washington	X	X		A	X		
Lac Tiffany	L3	5.0	SENW 30,37N,4E	St. Francois	X	X		A	X		
Lac Veron	L3	2.0	NWNW 30,37N,4E	St. Francois	X	X		A	X		
Lake Allaman	L3	6.0	NE 24,56N,30W	Clinton	X	X		A	X		
Lake Annette	L3	[65.0] 52.0	[01,44N,33W] NESW 1,44N,33W	Cass	X	X		B	X		
Lake Arrowhead	L3	101.0	18,54N,30W	Clinton	X	X		A	X		
Lake Arrowhead	L3	23.0	NW NE 31, 42N, 2E	Franklin	X	X		A	X		
Lake Briarwood	L3	[69.0] 65.0	[SW NE33,40N,04E] NWSE 33,40N,4E	Jefferson	X	X		A	X		
Lake Buteo	L3	7.0	SWNE 29,46N,24W	Johnson	X	X		A			
Lake Champetra	L3	58.0	NW13,45N,12W	Boone	X	X		A	X		
Lake Cherokee	L3	[6.0] 5.0	[14,36N,03E] SENE 14,36N,3E	Washington	X	X		B	X		
Lake Contrary	L3	291.0	26,27,35,57N,36W	Buchanan	X	X		A	X		
[Lake Fond du Lac] Fon-Du-Lac Reser	L3	24.0	[SUR 3011,43N,05E] LG 1331,43N,5E	Jefferson	X	X		A	X		
[Lake Forest] Lake Anne	L3	[81.0] 82.0	[SUR 2046,38N,07E] LG 2046,38N,7E	St. Genevieve	X	X		B			
Lake Girardeau	L3	144.0	SW SW09,30N,11E	Cape Girardeau	X	X		B	X		
Lake Jacomo	L3	998.0	NE NW11,48N,31W	Jackson	X	X		A	X		
Lake Killarney	L3	61.0	NW NW01,33N,04E	Iron	X	X		A	X		
Lake Lacawanna	L3	10.0	SE SE 11,38N,05E	St. Francois	X	X		B	X		
Lake Lincoln	L3	[88.0] 51.0	[SW SE08,49N,01E] SWSE 8,49N,1E	Lincoln	X	X		A	X		
Lake Lochaweeno	L3	39.0	24,47N,08W	Callaway	X	X		A	X		
Lake Loraine	L3	[37.0] 42.0	[SUR 1970, 41N,04E] LG 1970,41N,4E	Jefferson	X	X		A	X		
Lake Lotawana	L3	487.0	SE SE29,48N,30W	Jackson	X	X		A	X		
Lake Lucern	L3	41.0	NE SE06,46N,01W	Warren	X	X		A			

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Lake Luna	L3	17.0	[NE 4,44N,31W] NENW 4,44N,31W	Cass	X	X		B	X		
Lake Marie	L3	60.0	NE NW 36,66N,24W	Mercer	X	X		A			
Lake McGinness	L3	50.0	NW20,55N,30W	Clinton	X	X		B			
Lake Montowese	L3	[39.0] 38.0	[27,43N,04E] NWNW 27,43N,4E	Jefferson	X	X		A	X		
Lake Nehai Tonkayea	L3	228.0	NW NE11,55N,18W	Chariton	X	X		A			
Lake Nell	L3	24.0	22,47N,31W	Jackson	X	X		B	X		
Lake Niangua	L3	256.0	19,37N,17W	Camden	X	X		A	X		
Lake Northwood	L3	77.0	SE NE33,43N,05W	Gasconade	X	X		A			
Lake Ocie	L3	62.0	LG 884,37N,7E	Ste. Genevieve	X	X		A			
Lake of the Oaks	L3	53.0	SE SW07,63N,06W	Clark	X	X		A	X		
Lake of the Ozarks	L2	59,520.0	SE SE19,40N,15W	Camden	X	X		A	X		
Lake of the Woods	L3	3.0	NE SW 02,48N,12W	Boone	X	X		B			
Lake Paho	L3	273.0	NE SE25,65N,25W	Mercer	X	X		B			
Lake Serene	L3	59.0	NW NE03,42N,02E	Franklin	X	X		A	X		
Lake Sherwood	L3	120.0	SW SE11,45N,01W	Warren	X	X		A			
[Lake Showme] Memphis Lake	L1	[214.0] 224.0	[15,65N,12W] SENE 15,65N,12W	Scotland	X	X		B		X	
Lake Springfield	L3	293.0	19,28N,21W	Greene	X	X		B	X		X
Lake St. Clair #1	L3	52.0	SW SE02,41N,01W	Franklin	X	X		A	X		
Lake St. Louis	L3	444.0	SUR 54 (NE SW26,47N,02E)	St. Charles	X	X		A			
Lake Ste. Louise	L3	[71.0] 72.0	[SUR 929 (SW SW27,47N,02E)] LG 929,47N,2E	St. Charles	X	X		A			
Lake Taneycomo	L2	2,118.6	SW NE8,23N,20W	Taney	X	X	X	A	X	X	
Lake Tapawingo	L3	83.0	NE NE34,49N,31W	Jackson	X	X		A	X		
Lake Thunderbird	L3	33.0	NE,NW 5,41N,01E	Franklin	X	X		A	X		
Lake Thunderhead	L1	859.0	NE NE15,66N,19W	Putnam	X	X		A	X	X	
Lake Timber Ridge	L3	35.0	SW SE 16,43N,06W	Gasconade	X	X		A	X		
Lake Tishomingo	L3	[115.0] 112.0	[NE SE5,41N,04E (SUR 3027)] LG 3027,41N,4E	Jefferson	X	X		A	X		
Lake Tom Sawyer	L3	4.0	[04,54N,08W] SESE 4,54N,8W	Monroe	X	X		A			
Lake Torino	L3	7.0	20,42N,02E	Franklin	X	X		B	X		
Lake Tywappity	L3	43.0	SW SE08,29N,13E	Scott	X	X		A			
Lake Viking	L1	552.0	09,59N,28W	Daviess	X	X		A	X	X	
Lake Wanda Lee	L3	97.0	[SUR 884, 37N, 7E] LG 884,37N,7E	Ste. Genevieve	X	X		A			
Lake Wappapello	L2	8,200.0	[SE NE3,26N,07E] SENE 3,26N,7E	[Wayne/Butler] Wayne	X	X		A	X		
Lake Wauwanoka	L3	93.0	[SE NW01,40N,04E] NWSE 1,40N,4E	Jefferson	X	X		A	X		
Lake Winnebago	L3	272.0	NE NW09,46N,31W	Cass	X	X		A	X		
Lakeview Park Lake	L3	[25.0] 24.0	[SW35,51N,09W] SWNE 35,51N,9W	Audrain	X	X		B			
Lakewood Lakes	L3	279.0	NE NE07,48N,31W & SW SW 5, 48N, 31W	Jackson	X	X		A	X		
Lamar Lake	L1	148.0	SW NW32,32N,30W	Barton	X	X		B		X	
Lamine River C.A. Lakes	L3	37.0	25,26,27,36,46N,19W; 2,11,45N,19W; 7,18,45N,18W.	Cooper/Morgan	X	X		B	X		
[Lancaster City Lake - New] Lancaster City Lake - South	L1	56.0	[23,66N,15W] NWNE 23,66N,15W	Schuyler	X	X		B		X	
[Lancaster Lake - Old] Lancaster City Lake - North	L1	23.0	[SW NE14,66N,15W] SWNW 14,66N,15W	Schuyler	X	X		B		X	
Lane Lake	L3	10.0	32,37N,01W	Washington	X	X		A	X		
Lawson City Lake	L1	25.0	31,54N,29W	Ray	X	X		A	X	X	
Leisure Lake	L3	38.0	NE SE05,61N,25W	Grundy	X	X		A			
Leisure Lake	L3	45.0	33,48N,08W	Callaway	X	X		A	X		
Lewis & Clark Lake	L3	403.0	27,28,33,55N,37W	Buchanan	X	X		A	X		

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Lewis Lake	L3	6.0	SE, NE 10,26N,11E	Stoddard	X	X		B			
[Lewistown Lake]	L1	35.0	NW SW08,61N,08W	Lewis	X	X		B	X	X	
City of Lewistown Reservoir											
Liberty Park Lake	L3	1.0	04,45N,21W	Pettis	X	X		B			
Limpp Community State Lake	L3	27.0	29,61N,32W	Gentry	X	X		B	X		
Linneus Lake	L1	17.0	NE SW36,59N,21W	Linn	X	X		B	X	X	
Lions Lake	L3	8.0	SW SE 26,46N,26W	Johnson	X	X		B	X		
Lions Lake	L3	11.0	16,44N,01W	Franklin	X	X		B	X		
Lisle Pond	L3	22.0	[05,43N,33W] SWNE 5,43N,33W	Cass	X	X		B	X		
Little Compton Lake	L3	36.0	29,32,55N,21W	Carroll	X	X		B	X		
Little Dixie Lake	L3	176.0	SW SE26,48N,11W	Callaway	X	X		B	X		
Loch Leonard	L3	27.0	[SE18,46N,30W] SESE 18,46N,30W	Cass	X	X		B	X		
Loggers Lake	L3	21.0	10,15,31N,03W	Shannon	X	X		A	X		
Lone Jack Lake	L3	31.0	11,47N,30W	Jackson	X	X		B	X		
Lone Tree Lake	L3	21.0	N NE15,46N,6W	Montgomery	X	X		B	X		
[Lonedell Lake]	L3	[40.0] 30.0	[16,40N,02E]	Franklin	X	X		B	X		
Aggrevention Lake			SWSW 9,40N,2E								
Long Branch Lake	L2	2,686.0	NW18,57N,14W	Macon	X	X		A	X	X	
Long Lake	L3	10.0	NW NW 03,25N,12E	Stoddard	X	X		B			
Longview Lake	L2	953.0	04,47N,32W	Jackson	X	X		A	X		
Lost Valley Lake	L3	37.0	SE NE17,43N,04W	Gasconade	X	X		A	X		
Lower Taum Sauk Lake	L3	200.0	33,33N,02E	Reynolds	X	X		B	X		
Lucky Clover Lake	L3	20.0	20,38N,04W	Crawford	X	X		A	X		
[Mac Lake - Ziske]	L3	28.0	[SW NE 17,34N,05W] SWNE 17,34N,5W	Dent	X	X		B	X		
Macon Lake	L3	189.0	SE NW17,57N,14W	Macon	X	X		B		X	
Malta Bend Comm. Lake	L3	4.0	25,51N,23W	Saline	X	X		B	X		
Manito Lake	L3	77.0	08,09,44N,17W	Moniteau	X	X		B	X		
Maple Leaf Lake	L3	127.0	04,48N,26W	Lafayette	X	X		B	X		
Marais Temps Clair	L3	725.7	19,48N,06E and 24,48N,5E	St. Charles	X	X		B	X		
Marceline City Lake (New)	L1	200.0	SW SE14,56N,19W	Chariton	X	X		B		X	
Marceline Reservoir	L1	68.0	SE 28,57N,18W	Linn	X	X		B		X	
Mark Twain Lake	L2	[18,132.0] 18,600.0	[26,55N,07W] NENW 26,55N,7W	Ralls	X	X		A	X	X	
[Marshall Habilitation Center Lake]	L3	[10.0] 12.0	11,50N,21W	Saline	X	X		B	X		
Marshall State School Lake											
Martin Lakes	L3	17.0	11,26N,11E	Stoddard	X	X		B			
Maysville Lake	L1	27.0	NE NE 4, 58N,31W	DeKalb	X	X		B	X	X	
Maysville Lake	L1	12.0	NW NE03,58N,31W	DeKalb	X	X		B	X	X	
McCormack Lake	L3	9.0	NW SW 24,25N,04W	Oregon	X	X		A	X		
McDaniel Lake	L1	218.0	NE SE26,30N,22W	Greene	X	X		B		X	
Melody Lake	L3	32.0	[27,42N,03W] NWSW 27,42N,3W	Franklin	X	X		A	X		
Memphis Reservoir	L1	39.0	[NE NE14,65N,12W] NENE 14,65N,12W	Scotland	X	X		B		X	
Middle Fork Water Comp.	L1	103.0	NW SW06,63N,31W	Gentry	X	X		B	X	X	
Milan Lake North	L1	13.0	SE SE02,62N,20W	Sullivan	X	X		B		X	
Milan Lake South	L1	37.0	SE SE,02,62N,20W	Sullivan	X	X		B		X	
Mineral Area College Quarry Pond	L3	2.0	NENE 9,36N,5E	St. Francois	X	X		A			
Mineral Lake	L3	[8.0] 10.0	[01,42N,03W] SWNE 1,42N,3W	Franklin	X	X		B	X		
Mononame 846 Lake	L3	3.0	34,37N,2W	Crawford	X	X		B			
Monopoly Lake	L3	1,045.0	30,27N,08E	[Stoddard/Wayne] Wayne	X	X		B	X		
Monroe City Lake	L1	[94.0] 93.0	[SW,NE,34,56N,07W] SWNE 34,56N,7W	Ralls	X	X		A	X	X	
[Monroe City Lake A]	L1	17.0	[NW NW13,56N,08W] NWNW 13,56N,8W	Monroe	X	X		B		X	
Monroe Lake A											
[Monroe City Lake B]	L1	55.0	[30,56N,07W]	Monroe	X	X		B	X	X	

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Monroe Lake B			SWNW 30,56N,7W								
Monsanto Lake	L3	18.0	[19, 20,36N,05E] SENE 20,36N,5E	St. Francois	X	X		A	X		
Montrose Lake	L3	1,444.0	NE NW33,41N,27W	Henry	X	X		B			X
Mozingo Lake	L1	898.0	13,64N,35W	Nodaway	X	X		B	X	X	
New Cambria Lake	L1	9.0	SW NE07,57N,16W	Macon	X	X		B		X	
Nims Lake	L3	251.0	SW NW24,34N,06E	Madison/St. Francois	X	X		A			
Noble Lake	L3	26.0	25,26N,11W	Douglas	X	X		A			
Nodaway Lake	L3	73.0	SW NE20,65N,35W	Nodaway	X	X		B	X		
Norfolk Lake	L2	1,000.0	21N,12W	Ozark	X	X		A	X		
North Bethany City Reservoir	L3	78.0	SE27,64N,28W	Harrison	X	X		A	X		
North Lake	L3	19.0	[SW NE28,45N,31W] NESW 28,45N,31W	Cass	X	X		B	X		
North Sever Lake	L3	12.5	20,63N,11W	Knox	X	X		B	X		
O'Brian Lake	L3	50.0	[NW NW19,47N,01E] NW 19,47N,1E	[St. Charles/Warren] St. Charles	X	X		B			
Odessa Lake	L1	87.0	NW NE15,48N,28W	Lafayette	X	X		B	X	X	
Odessa Lake (Old)	L1	22.0	NW NW14,48N,28W	Lafayette	X	X		B		X	
Old Bethany City Reservoir	L1	18.0	02,63N,28W	Harrison	X	X		B		X	
Old Mud Lake	L3	126.0	16,20,21, 56N,36W	Buchanan	X	X		B			
Old Plattsburg Lake	L1	15.0	13,55N,32W	Clinton	X	X		B		X	
Opossum Hollow Lake	L3	63.0	SW NE29,39N,03W	Crawford	X	X		A	X		
Oscie Ora Acres Lake	L3	50.0	[SE NW10,28N,33W] NWSE 10,28N,33W	Jasper	X	X		B			
Otter Lake	L3	250.0	17,24N,09E	Stoddard	X	X		B	X		
Painted Rock Lake	L3	5.0	11,42N,11W	Osage	X	X		B			
Palmer Lake	L3	102.0	22,36N,01E	Washington	X	X		A	X		
Panther Creek D-1 Lake	L3	28.0	32,65N,26W	Harrison	X	X		B			
Parker Lake #1	L3	20.0	SE SE 31,35N,09E	Perry	X	X		A			
Parker Lake #2	L3	80.0	NE SW32,35N,09E	Perry	X	X		A			
Parole Lake	L3	42.0	07,36N,01E	Washington	X	X		A	X		
Paul Herring Lake	L3	44.0	NW SW17,46N,09W	Callaway	X	X		B			
Peabody Wildlife Area Lakes	L3	36.0	04/09,38N,32W	Bates	X	X		B	X		
Peaceful Valley Lake	L3	158.0	NE NE25,42N,06W	Gasconade	X	X		A			
[Peculiar Lake]	L1	[25.0] 27.0	[SE SW22,45N,32W] SWSE 22,45N,32W	Cass	X	X		B		X	
Peculiar City Reservoir											
Penn's Pond Lake	L3	8.0	06,34N,11W	Pulaski	X	X		B	X		
Perco Lakes	L3	21.7	SW5, NW8, 34N,10E	Perry	X	X		B			
Perry C.A. Lakes	L3	16.4	28.33.34.36.48N,24W;30,48 N,23W	Johnson	X	X		B	X		
Perry County Community Lake	L3	89.0	SW NE22,35N,10E (SUR 856)	Perry	X	X		B			
Pershing St. Park Lakes	L3	12.0	2,11,57N,21W	Linn	X	X		A			
Peters Lake	L3	62.0	NW NW4,50N,16W	Howard	X	X		B	X		
Pike Lake	L3	17.0	02,59N,25W	Livingston	X	X		A	X		
Pim Lake	L3	7.0	SWNW 20,36N,5E	St. Francois	X	X		A	X		
Pinewoods Lake	L3	22.0	07,26N,03E	Carter	X	X		B	X		
Pinnacle Lake	L3	115.0	SE NE24,47N,05W	Montgomery	X	X		A			
Plattsburg 6 Mi. Lane Lk.	L3	57.0	SW SE11,55N,32W	Clinton	X	X		B		X	
Pleasant Hill Lake	L1	91.0	SW SE01,46N,31W	Cass	X	X		B	X	X	
Plover Lake	L3	14.0	15,47N,31W	Jackson	X	X		B	X		
Poague C A Lakes	L3	80.0	19,30,42N,26W, 24,42N,27W	Henry	X	X		B	X		
Pomme de Terre Lake	L2	7,820.0	SW NE2,36N,22W	Hickory/Polk	X	X		A	X		
Pony Express Lake	L3	240.0	NE 33,58N,31W	DeKalb	X	X		A	X		
Port Hudson Lake	L3	48.0	16,43N,03W	Franklin	X	X		B	X		
Port Perry Lake	L3	155.0	NE SE08,34N,09E	Perry	X	X		B			
Potosi Lake	L3	20.0	[SW NW 35,37N,03E] SWNW 35,37N,3E	Washington	X	X		A	X		
Prairie Home C.A. Lakes	L3	20.0	4,5,6,46N,15W	Cooper/Moniteau	X	X		B			
Prairie Lee Lake	L3	144.0	NE SW27,48N,31W	Jackson	X	X		A	X		
Primrose Lake	L3	33.0	23,38,04E	St. Francois	X	X		B	X		

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WATER BODY	CLASS	ACRES	LOCATION	COUNTY(IES)	LWW	AQL	CDF	WBC	SCR	DWS	IND
Quartz Lake	L3	5.0	NWNE 13,60N,6W	Lewis	X	X		B	X		
Radio Springs Lake	L3	8.0	08,35N,31W	Vernon	X	X		B	X		
Railroad Lake	L3	8.0	34,45N,15W	Moniteau	X	X		B	X		
Raintree Lake	L3	[248.1] 248.0	[06,46N,31W]	Cass	X	X		A	X		
Raintree Plantation Lake	L3	115.0	NENE 6,46N,31W [29,41N,04E]	Jefferson	X	X		A	X		
Ray County Community Lake	L3	23.0	NWNE 29,41N,4E								
Raymond Claus Lake	L3	23.0	13,52N,28W	Ray	X	X		A	X		
Rice Lake East	L3	8.7	SE SE17,27N,11E	Stoddard	X	X		B			
Rinquelin Trail Community Lake	L3	11.0	09,27N,11E	Stoddard	X	X		B			
Ripley Lake	L3	27.0	NE 29,39N,11W	Maries	X	X		B	X		
Riss Lake	L3	18.0	10,23N,01E	Ripley	X	X		A	X		
Roach Lake	L3	134.0	SW SW25,51N,33W	Platte	X	X		B	X		
Robert G. Delaney Lake	L3	106.0	30,57N,23W	Livingston	X	X		A	X		
Roby Lake	L3	110.0	30,27N,16E	Mississippi	X	X		B			
Rock House Lake	L1	10.0	34/35,33N,11W	Texas	X	X		A	X		
Rocky Fork Lake	L3	62.0	NE SW 36,65N,27W	Harrison	X	X		A	X	X	
Rocky Hollow Lake	L3	60.0	NW SE31,50N,12W	Boone	X	X		B			
Rotary Lake	L3	20.0	[SE33,53N,30W]	Clay	X	X		B	X		
[Rothwell Lake]	L3	5.0	SESW 33,53N,30W								
Old Reservoir	L3	[27.0] 20.0	LG 216,31N,12E	Cape Girardeau	X	X		B	X		
Salisbury City Lake (Pine Ridge Lake)	L3		[SE NE03,53N,14W]	Randolph	X	X		B	X	X	
Savannah City Reservoir	L1	25.0	SENE 3,53N,14W	Chariton	X	X		B	X		
Sayersbrook Lake	L3	20.0	15,53N,17W								
Schell Lake	L3	36.0	07,59N,35W	Andrew	X	X		A	X	X	
[Schuyler Co. PWS #1 Lake]	L3	371.0	NE SE28,38N,01E	Washington	X	X		B			
PWSD 1 L Reservoir	L1	33.0	SE NE06,37N,28W	St. Clair/Vernon	X	X		A	X		
[Scioto Lake]	L3		[SE SE04,64N,015W]	Schuyler	X	X		B		X	
Lake Scioto	L3	5.0	SESE 4,64N,15W								
Sears Community Lake	L3	32.0	[NE NE 30,38N,06W]	Phelps	X	X		B			
See Tal Lake	L3	11.0	NENE 30,38N,6W								
Sequiota Park Lake	L3	32.0	18,63N,19W	Sullivan	X	X		A	X		
Settles Ford C.A. Lakes	L3	11.0	NW NW01,45N,05W	Gasconade	X	X		B			
Seven Springs Lake	L3	3.0	09,28N,21W	Greene	X	X		B			
[Shawnee Lake - Turner]	L3	968.0	33,43N,29W;4,5,8-10,15-18,42N,29W;13,42N,30W	Bates	X	X		B	X		
Lake Turner	L3	18.0	[23-24,36N,06W]	Phelps	X	X		A	X		
Shelbina Lake	L1	15.0	NWSW 24,36N,6W								
Shelbyville Lake	L1	46.0	[SW NW 17,34N,05W]	Dent	X	X		B	X		
Shepard Mountain Lake	L1		SWNW 17,34N,5W								
[Silver Lake]	L3		[NE SW20,57N,10W]	Shelby	X	X		B	X	X	
Silverlake Enterprises Lake	L3		NESW 20,57N,10W								
Silver Lake-Levee 3	L3	32.0	SE SE19,58N,10W	Shelby	X	X		B	X	X	
Simpson Park Lake	L3	21.0	01,33N,03E	Iron	X	X		B	X	X	
Sims Valley Community Lake	L3	54.0	[SW SW16,46N,32W]	Cass	X	X		B	X		
Smithville Lake	L2	2,464.0	SWSW 16,46N,32W								
Snow Hollow Lake	L3	246.0	06,55N,20W	Chariton	X	X		B			
South Pool-Levee 3	L3	64.0	NWNE 16,44N,5E	St. Louis	X	X		A			
Spencer Lake	L3	42.0	17,20,27N,08W	Howell	X	X		A	X		
Sportsman Lake	L2	7,190.0	E SW13,53N,33W	Clay	X	X		A	X	X	
Spring Fork Lake	L3	31.0	26/27,34N,03E	Iron	X	X		B	X		
Spring Lake	L3	263.0	1,2,11,12,13,55N,21W	Chariton	X	X		B			
Squaw Creek NWR Pools	L3	7.0	NW19,66N,14W	Schuyler	X	X		B			
Sterling Price Community Lake	L1	7.0	NE SE,04,49N,06W	Montgomery	X	X		B		X	
Stockton Lake	L1	178.0	NE SW21,44N,21W	Pettis	X	X		B	X	X	
Strobel Lake	L3	87.0	10,61N,16W	Adair	X	X		A			
	L3	5.0	NESW 33,40N,4E	Jefferson	X	X		A			
	L3	1,230.0	36,61N,39W	Holt	X	X		B			
	L3	23.0	17,53N,17W	Chariton	X	X		A	X		
	L2	[23,680.0] 24,945.0	[NE NE15,34N,26W]	Cedar	X	X		A		X	
	L3		NENE 15,34N,26W								
	L3	33.0	SW SW 01,27N,09E	Stoddard	X	X		B			

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WATER BODY	CLASS	ACRES	LOCATION	COUNTY(IES)	LWW	AQL	CDF	WBC	SCR	DWS	IND
Sugar Creek Lake	L1	308.0	NE SE16,54N,14W	Randolph	X	X		B		X	
Sullivan City Lake	L3	5.0	NE NW 20,40N,02W	Crawford	X	X		B			
Summerset & Fisherman's Lakes	L3	75.0	SW15,39N,04E	Jefferson	X	X		A	X		
Sunfish Lake	L3	27.0	SUR 3097. 155. 1840, 47N,07E	St. Louis	X	X		B	X		
Sunnen Lake	L3	206.0	SW SE04,37N,01E	Washington	X	X		A			
Sunrise Lake	L3	[21.0] 22.0	[NE SW 36,39N,04E] SWNE 36,39N,4E	Jefferson	X	X		A	X		
Sunset Lake	L3	50.2	[NW SE33,39N,07E] NWSE 33,39N,07E	Ste. Genevieve	X	X		B			
Sunset Lake	L3	6.0	13,44N,12W	Cole	X	X		B			
Sunshine Lake	L3	500.0	19,29,32,51N,27W	Ray	X	X		A	X		X
Swan Lake-Levee 5	L3	1,425.0	[10,55N,21W] 34,56N,21W	Chariton	X	X		B			
Table Rock Lake	L2	41,747.0	SW NW22,22N,22W	Stone	X	X		A	X		
Tarsney Lake	L3	17.0	[SE SE22,48N,30W] SESE 22,48N,30W	Jackson	X	X		A	X		
Tea Lake No. 1	L3	[25.0] 27.0	[08,41N,04W] SWNE 8,41N,4W	Gasconade	X	X		B	X		
Teal Lake	L3	[84.0] 83.0	[NE SW36,51N,09W] NESW 36,51N,09W	Audrain	X	X		B	X		
[Tebo Freshwater Lake]	L3	250.0	[SW SW25,43N,25W] SESE 26,43N,25W	Henry	X	X		B			
No. 111 Lake											
[Ten Mile Pond]	L3	[70.0] 73.0	[07,04,03,24N,16E] NENE 17,24N,16E	Mississippi	X	X		B			
Tenmile Pond											
[Terre Du Lac Lakes]	L3	[371.4] 103.0	[(18,19,20,28,29,30,31)37N,4St. Francois E,25,37N,3E]	St. Francois	X	X		A	X		
Lac Capri			NESE 30,37N,4E								
Thomas Hill Reservoir	L2	4,400.0	NE SE24,55N,16W	Randolph	X	X		A		X	X
Thomas Lake	L3	3.0	LG 2969,35N,5E	St. Francois	X	X		B	X		
[Timberline Lakes]	L3	[51.0] 39.0	[23,24,38N,04E] NWSW 24,38N,4E	St. Francois	X	X		A	X		
Lake Timberline											
Tobacco Hills Lake	L3	16.0	NW11,53N,35W	Platte	X	X		B	X		
Tom Bird Blue Hole	L3	6.0	29,27N,18E	Mississippi	X	X		B			
Trenton Lake Lower	L1	103.0	SW 15,61N,24W	Grundy	X	X		B		X	
Trenton Lake Upper	L1	68.0	NE SE15,61N,24W	Grundy	X	X		B		X	
Tri-City Lake	L3	27.0	SENW 24,51N,12W	Boone	X	X		B	X		
Twin Borrow Pits	L3	44.0	13,20N,13E	Pemiscot	X	X		B	X		
Twin Lake	L3	49.0	NW NW31,66N,23W	Mercer	X	X		B			
Twin Lakes	L3	22.9	SW SW,22,48N,13W	Boone	X	X		A	X		
Union City Lake	L3	5.0	27,43N,01W	Franklin	X	X		B			
Unionville (Old) Lake	L1	13.0	34,66N,19W	Putnam	X	X		A	X	X	
Unionville Reservoir	L3	74.0	27,66N,19W	Putnam	X	X		B			
Unity Village Lake #1	L1	16.0	25,48N,32W	Jackson	X	X		B	X	X	
Unity Village Lake #2	L1	26.0	24,48N,32W	Jackson	X	X		B	X	X	
Valle Lake	L3	42.0	[31,39N,05E] NESW 31,39N,5E	Jefferson	X	X		A	X		
Valley Water Mills Pond	L1	14.0	NESW 5,29N,21W	Greene	X	X		B	X	X	
Van Meter St. Park Lake	L3	8.0	24,52N,22W	Saline	X	X		A	X		
Vandalia Community Lake	L3	35.0	SE35,52N,06W	Audrain	X	X		B			
[Vandalia Reservoir]	L1	28.0	[NE NE12,53N,05W] NENE 12,53N,5W	Pike	X	X		B	X	X	
Pete Steiner Reservoir											
Wahoo Lake	L3	10.0	14,38N,04E	St. Francois	X	X		B	X		
Wakonda Lake	L3	78.0	13,14,60N,06W	Lewis	X	X		A	X		
Walt Disney Lake	L3	19.0	31,57N,18W	Linn	X	X		A			
[Water Works Lake]	L1	[22.0] 25.0	[NE SE 03,53N,14W] NESE 3,53N,14W	Randolph	X	X		B	X	[X]	
Rothwell Lake											
Wutkins Mill Lake	L3	87.0	NW 22,53N,30W	Clay	X	X		A	X		
Woukomis Lake	L3	76.0	SW 17,51N,33W	Platte	X	X		A	X		
Weatherby Lake	L3	185.0	SW SE15,51N,34W	Platte	X	X		A	X		
Wellsville City Lake	L1	12.0	NW SE 33,50N,06W	Montgomery	X	X		A		X	
West Arrowhead Lake	L3	58.0	18,23N,08W	Howell	X	X	X	B	X		

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WATER BODY	CLASS	ACRES	LOCATION	COUNTY(IES)	LWW	AQL	CDF	WBC	SCR	DWS	IND
Whetstone Creek C.A. Lakes	L3	62.0	5,6,8,9,48N,07W; 31,32,49N	Callaway	X	X		B	X		
			7W								
Whispering Valley Lakes	L3	30.0	35,44N,03W	Franklin	X	X		A	X		
[WhitesideLake White Memorial SWA]	L3	28.0	[SW SUR 1686,51N,01W]	Lincoln	X	X		B	X		
Whiteside Lake			LG 1686,51N,1W								
Wildwood Lake	L3	17.0	NE 09,48N,32W	Jackson	X	X		B			
Willow Brook Lake	L1	53.0	SE NE 04,58N,13W	DeKalb	X	X		B			X
Willow Lake	L3	29.0	27-34,34N,32W	Vernon	X	X		B	X		
Willowwood Lake	L3	45.0	26 & 35,48N,05E	St. Charles	X	X		B	X		
Windsor City Lake	L3	16.0	06,43N,23W	Peris	X	X		B			
Winegar Lake	L3	8.0	18,43N,13W	Cole	X	X		B			
Wing Lake	L3	19.9	[NW SW 14, 35N,03E]	Washington	X	X		A	X		
			SWNW 14,35N,3E								
Wolf Bayou Mud Bayou	L3	37.0	04,19N,13E	Pemiscot	X	X		B	X		
Worth County Community Lake	L3	17.0	32,65N,32W	Worth	X	X		B	X		
Wyaconda Lake	L1	9.0	NW NW33,65N,09W	Clark	X	X		B	X	X	

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TABLE H-STREAM CLASSIFICATIONS AND USE DESIGNATIONS

WATER BODY	CLASS	MILES	FROM	TO	COUNTY	COUNTY 2	IRR	LWW	AQL	CLF	CDF	WBC	SCR	DWS	IND
100 K Statewide Extent	C	84,845.	Statewide	Statewide	Statewide		x	x	x			B	x		
AB Cr.	C	4.2	Mouth	32,37N,18W	Dallas	Camden		x	x			B			
Ackerman Ditch	C	14.1	Mouth	24,24N,6E	Butler		x	x	x			B			
Agee Cr.	C	4.8	Mouth	24,61N,34W	Andrew			x	x			B			
Alder Br.	C	4.7	2,34N,26W	5,34N,25W	Cedar			x	x			B			
Alder Cr.	C	11.4	Mouth	21,35N,28W	Cedar			x	x			B			
Allen Br.	P	1.8	Mouth	22,37N,1E	Washington			x	x			B			
Allen Br.	C	1.5	22,37N,1E	34,37N,1E	Washington			x	x			B			
Allen Br.	C	3.0	Mouth	05,34N,05E	St. Francois			x	x			B			
Allen Cr.	C	6.4	Mouth	13,53N,12W	Monroe			x	x			B			
Alley Br.	P	1.5	Mouth	25,29N,5W	Shannon			x	x			B			
Alley Br.	C	2.6	25,29N,5W	22,29N,5W	Shannon			x	x			B			
Allie Cr.	C	2.6	Mouth	1,33N,10E	Cape Girardeau	Bollinger		x	x			B			
Anderson Br.	C	1.0	Mouth	31,45N,20W	Pettis			x	x			B			
Anderson Cr.	C	1.9	Mouth	[31,33N,09W] 31,33N,9W	Texas			x	x			B			
Andrews Br.	C	1.8	Mouth	Sur 3062,37N,6E	St. Francois			x	x			B			
Anthony Br.	P	0.5	Mouth	6,22N,5W	Oregon			x	x			B			
Antire Cr.	P	1.9	Mouth	34,44N,4E	St. Louis			x	x			B			
Apple Cr.	P	44.8	Mouth	21,34N,10E	Perry			x	x			A	x	x	
Apple Cr.	C	1.7	[16,34N,10E] 21,34N,10E	18,34N,10E	Perry			x	x			B			
Arapahoe Cr.	C	8.0	Mouth	11,61N,36W	Andrew			x	x			B			
Archer Cr.	P	1.2	Mouth	14,41N,20W	Benton			x	x			B			
Arnault Br.	P	2.2	Mouth	10,38N,2E	Washington			x	x			B			
Arnault Br.	C	1.0	10,38N,2E	15,38N,2E	Washington			x	x			B			
Arnold Cr.	C	1.1	Mouth	24,40N,1E	Washington			x	x			B			
Arthur Cr.	P	5.9	Mouth	14,31N,9W	Texas			x	x			B			
Arthur Cr.	C	2.5	14,31N,9W	25,31N,9W	Texas			x	x			B			
Ash Ditch	P	6.6	Mouth	13,25N,14E	New Madrid			x	x			B			
Ash Ditch	C	8.0	13,25N,14E	5,26N,15E	New Madrid	Mississippi		x	x			B			
Ash Slough Ditch	P	17.2	Mouth	35,26N,13E	New Madrid		x	x	x			B	x		
Asher Cr.	P	8.7	Mouth	4,30N,23W	Polk	Greene		x	x			B			
Asher Cr.	C	4.0	4,30N,23W	14,30N,23W	Greene			x	x			B			
Asher Cr.	P	1.0	Mouth	1,26N,7E	Wayne			x	x			B			
Asher Cr.	C	1.2	1,26N,7E	2,26N,7E	Wayne			x	x			B			
Asher Hollow Cr.	C	4.0	Mouth	24,37N,06W	Crawford	Phelps		x	x			B			
Ashley Br.	P	[0.5]/0.4	Mouth	30,39N,1W	Washington			x	x			B			
Ashley Br.	C	1.6	30,39N,1W	32,39N,1W	Washington			x	x			B			
Ashley Cr.	P	2.5	Mouth	[35,32N,7W] 34,32N,7W	Dent			x	x			B			
Ashly Br.	C	0.7	Mouth	27,38N,1E	Washington			x	x			B			
Aslinger Br.	P	[1.0]/1.9	Mouth	16,32N,8E	Madison			x	x			B			
Aslinger Br.	C	1.0	16,32N,8E	[County Line] 10,32N,8E	Madison			x	x			B			
Atwell Cr.	P	1.2	Mouth	2,38N,12W	Miller			x	x			B			

IRR LWW AQL CLF CDF WBC SCR DWS IND

IRR-Irrigation  
LWW-Livestock & Wildlife Watering  
AQL-Protection of Warm Water Aquatic Life  
and Human Health Fish Consumption

CLF-Cool Water Fishery  
CDF-Cold Water Fishery  
WBC-Whole Body Contact Recreation

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WATER BODY	CLASS	MILES	FROM	TO	COUNTY	COUNTY 2	IRR	LWW	AQL	CLF	CDF	WBC	SCR	DWS	IND
Atwell Cr.	C	2.0	2,38N,12W	11,38N,12W	Miller			x	x			B			
Auxvasse Cr.	P	8.2	Mouth	8,46N,8W	Callaway			x	x			B	x		
Auxvasse Cr.	C	39.9	8,46N,8W	22,49N,10W	Callaway			x	x			B			
Avery Hollow	C	0.9	Mouth	04,38N,03W	Crawford			x	x			B			
Bachelor Cr.	C	6.8	Mouth	19,49N,7W	Callaway			x	x			B			
Back Cr.	C	3.8	Mouth	11,35N,6E	St. Francois			x	x			B	x		
Bagby Br.	C	2.3	Mouth	1,52N,16W	Randolph			x	x			B			
Bailey Br.	P	1.8	Mouth	31,36N,1W	Washington			x	x			B			
Baileys Cr.	P	15.7	Mouth	5,44N,7W	Gasconade	Osage		x	x			B			
Baileys Cr.	C	6.6	5,44N,7W	20,44N,7W	Osage			x	x			B			
Baker Br.	C	3.5	Mouth	35,38N,28W	St. Clair			x	x			B			
Baker Cr.	C	3.5	32,29N,15W	12,28N,16W	Wright			x	x			B			
Bald Ridge Cr.	C	10.0	Mouth	13,33N,11W	Pulaski	Texas		x	x			A			
Balt Br.	P	1.3	Mouth	27,40N,4E	Jefferson			x	x			B			
Balt Br.	C	1.0	27,40N,4E	23,40N,4E	Jefferson			x	x			B			
Balt Pond Hollow	C	1.5	Mouth	32,24N,11W	Ozark			x	x			B			
Baltimore Cr.	C	2.0	Mouth	33,33N,9E	Bolinger			x	x			B			
Bank Br.	C	5.5	Mouth	35,37N,17W	Camden			x	x	x		B	x		
Bannister Hollow	C	4.3	Mouth	36,38N,19W	Camden			x	x			B			
Barber Cr.	C	9.1	Mouth	3,65N,22W	Sullivan	Putnam		x	x			B			
Barbers Cr.	C	3.3	Mouth	8,25N,19W	Christian			x	x			B			
Barker Cr.	C	15.0	Mouth	/09,43N,23W/	Henry	Pettis		x	x			B			
Barn Hollow	C	8.2	Mouth	9,42N,23W 18,27N,7W	Texas	Howell		x	x			B			
Barnes Cr.	C	1.4	Mouth	34,29N,7E	Wayne			x	x			B			
Barnes Cr.	C	1.0	Mouth	4,33N,6E	Madison			x	x			B			
Barney Cr.	C	4.8	Mouth	24,34N,3W	Dent			x	x			B			
Barnitz Prong	P	4.1	Mouth	21,34N,7W	Dent			x	x			B			
Barren Cr.	C	2.8	Mouth	3,33N,24W	Polk			x	x			[B]	x		
Barren Cr.	C	2.6	State Line	8,21N,11W	Ozark			x	x			B			
Barren Fk.	P	7.7	Mouth	30,39N,13W	Miller			x	x	x		A			
Barren Fk.	C	2.6	30,39N,13W	5,38N,13W	Miller			x	x			A			
Barren Fk.	C	4.4	Mouth	5,43N,4W	Franklin	Gasconade		x	x			B			
Barren Fk.	C	11.6	Mouth	10,23N,14W	Ozark			x	x			B			
Barren Fk.	C	2.6	32,32N,4W	28,32N,4W	Dent			x	x			B			
Barren Fk.	P	2.0	Mouth	29,31N,4W	Shannon			x	x		x	B			
Barren Fk.	P	8.2	20,31N,4W	32,32N,4W	Shannon	Dent		x	x			B			
Barren Hollow	C	0.5	Mouth	16,33N,5E	Madison			x	x			B			
Barret Hollow	C	/1.5/2.5	Mouth	1,22N,15W	Ozark			x	x			B			
Bartlett Cr.	C	8.2	Mouth	9,49N,17W	Howard			x	x			B			
Basin Fk.	C	13.5	Mouth	17,44N,23W	Pettis			x	x			B			
Bass Cr.	C	4.4	Mouth	Hwy. 63	Boone			x	x			A			
Bates County Drainage Ditch	P	23.6	Mouth	2,39N,33W	Bates		x	x	x			A	x	x	
Bates Cr.	P	1.8	Mouth	16,37N,2E	Washington			x	x			B			
Bates Cr.	C	3.2	16,37N,2E	28,37N,2E	Washington			x	x			[B]	x		
Batts Cr.	C	5.3	Mouth	19,52N,16W	Chariton	Howard		x	x			B			
Bauer Br.	C	3.0	Mouth	29,43N,21W	Benton			x	x			B			

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Bny De Charles	P1	8.0	Mouth	14,58N,5W	Marion			x	x			A	x		
Baynham Br.	P	4.0	Mouth	17,26N,31W	Newton			x	x			B			
Bear Br.	C	8.7	Mouth	Hwy. 54	Audrain			x	x			B			
Bear Cr.	C	6.3	Mouth	9,32N,8W	Dent	Texas		x	x			B			
Bear Br.	C	3.6	Mouth	6,24N,15W	Ozark			x	x			B			
Bear Br.	C	2.2	Mouth	29,31N,3E	Reynolds	Iron		x	x			B			
Bear Br.	C	2.0	Mouth	19,44N,15W	Moniteau			x	x			B			
Bear Br.	C	1.5	Mouth	17,31N,10E	Bollinger			x	x			B			
Bear Br.	C	5.1	Mouth	4,24N,16W	Douglas	Ozark		x	x			B	x		
Bear Camp Cr.	C	4.8	Mouth	31,26N,1E	Carter			x	x			B			
Bear Claw Spring	P	0.2	Mouth	33,30N,08W	Texas			x	x			B			
Bear Cr.	C	6.0	Mouth	33,30N,8W 31,49N,12W	Boone			x	x			B	x		
Bear Cr.	C	1.0	Mouth	31,40N,14W	Miller			x	x			B			
Bear Cr.	C	1.8	Mouth	31,43N,9W	Osage			x	x			B			
Bear Cr.	C	36.2	Mouth	8,61N,14W	Shelby	Adair	x	x	x			B	x		
Bear Cr.	C	9.4	Mouth	2,44N,28W	Johnson			x	x			B			
Bear Cr.	C	7.4	Mouth	17,40N,27W	Henry			x	x			B			
Bear Cr.	P	3.4	Mouth	15,38N,24W	St. Clair			x	x			A	x		
Bear Cr.	C	4.1	15,38N,24W	35,38N,24W	St. Clair			x	x			B	x		
Bear Cr.	C	5.6	Mouth	5,33N,28W	Cedar			x	x			B			
Bear Cr.	P	30.7	Mouth	20,33N,23W	Cedar	Polk		x	x			B			
Bear Cr.	C	12.7	Mouth	22,35N,15W	Pulaski	Laclede		x	x			B	x		
Bear Cr.	C	1.8	Mouth	25,29N,11W	Texas			x	x			B			
Bear Cr.	P	2.7	Mouth	36,47N,5W	Montgomery			x	x			B			
Bear Cr.	C	3.0	36,47N,5W	20,47N,4W	Montgomery	Warren		x	x			B			
Bear Cr.	C	16.1	Mouth	4,48N,4W	Lincoln	Montgomery		x	x			B			
Bear Cr.	C	3.0	Mouth	8,37N,4E	St. Francois			x	x			B			
Bear Cr.	P	18.3	Mouth	25,30N,6E	Bollinger	Wayne		x	x			A			
Bear Cr.	P	5.0	Mouth	18,24N,21W	Taney			x	x			A	x		
Bear Cr.	C	5.8	18,24N,21W	36,25N,22W	Taney	Christian		x	x			A	x		
Bear Cr.	C	9.8	Mouth	15,54N,36W	Platte			x	x			B			
Bear Cr.	P	1.5	Mouth	34,43N,04E	Jefferson			x	x			B			
Bear Cr.	C	4.5	Mouth	29,52N,19W	Saline			x	x			B			
Bear Cr.	C	20.0/19.7	Mouth	33,65N,10W	Lewis	Scotland		x	x			B	x		
Bear Cr.	C	9.4	Mouth	8,59N,19W	Linn			x	x			B			
Bear Cr.	P	2.1	Mouth	32,57N,4W	Marion			x	x			B			
Bear Cr.	C	8.5	32,57N,4W	29,57N,5W	Marion			x	x			B	x		
Bear Cr.	C	9.3	Mouth	32,46N,25W	Johnson			x	x			B			
Bear Cr.	C	8.0	8,61N,14W	22,62N,15W	Adair			x	x			B			
Beaver Br.	P	2.0	Mouth	36,23N,33W	McDonald			x	x			B			
Beaver Br.	C	3.5	36,23N,33W	19,23N,32W	McDonald			x	x			B			
Beaver Br.	P	1.5	19,23N,32W	17,23N,32W	McDonald			x	x			B			
Beaver Cr.	P	24.1	Mouth	29,30N,12W	Wright	Texas		x	x	x		B			
Beaver Cr.	C	4.2	29,30N,12W	4,29N,12W	Wright			x	x			A			
Beaver Cr.	P	5.7	4,29N,12W	26,29N,12W	Wright	Texas		x	x			B			
Beaver Cr.	C	3.8	Mouth	33,37N,8W	Phelps			x	x			A	x		
Beaver Cr.	C	1.2	Mouth	14,40N,2W	Crawford			x	x			B			

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Beaver Cr.	P	44.5	Mouth	23,27N,17W	Taney	Douglas	x	x	x	x		A	x		
Beaver Cr.	C	2.0	23,27N,17W	10,27N,17W	Douglas			x	x			B			
Beaver Dam Cr.	C	5.0	Mouth	Hwy. 54	Audrain			x	x			B			
Beaverdam Cr.	P	9.5	Mouth	9,24N,4E	Butler	Ripley	x	x	x			A			
Beaverdam Cr.	C	2.0	9,24N,4E	5,24N,4E	Ripley			x	x			B			
Beaverdam Cr.	C	5.7	Mouth	02,46N,23W	Pettis			x	x			B			
Becky Cobb Cr.	C	2.7	Mouth	29,23N,13W	Ozark			x	x			B			
Bee Br.	C	0.7	Mouth	32,46N,23W	Pettis			x	x			B			
Bee Br.	C	5.9	Mouth	06,47N,23W	Pettis			x	x			B			
Bee Br.	C	5.3	Mouth	20,37N,30W	Vernon			x	x			B			
Bee Br.	C	5.0	Mouth	10,55N,17W	Chariton			x	x			B			
Bee Cr.	C	5.8	Mouth	7,53N,10W	Monroe			x	x			B			
Bee Cr.	C	1.6	Mouth	17,23N,21W	Taney			x	x		x	[B]	x		
Bee Cr.	C	5.5	Mouth	5,21N,20W	Taney			x	x			A			
Bee Cr.	C	29.4	Mouth	11,55N,35W	Platte	Buchanan		x	x			B	x		
Bee Fk.	C	[8.7/9.0]	Mouth	30,32N,1W	Reynolds			x	x	x		A			
Bee Rock Hollow	C	1.4	Mouth	33,31N,07W	Texas			x	x			B			
Bee Run	C	[2.1/1.4]	Mouth	[24,38N,04E]	St. Francois			x	x			B			
Beecham Br.	C	1.6	Mouth	24,38N,4E	Vernon			x	x			B			
Beef Br.	P	2.5	Mouth	01,36N,29W	Newton			x	x			B			
Beehole Hollow	C	2.0	Mouth	11,26N,33W	Butler			x	x			B			
Beeler Br.	P	1.2	Mouth	33,26N,4E	Texas			x	x			B			
Beeler Br.	C	1.2	7,28N,10W	7,28N,10W	Texas			x	x			B			
Beeman Br.	P	1.0	14,23N,34W	18,28N,10W	McDonald			x	x			B			
Belew Cr.	P	7.0	Mouth	24,23N,34W	Jefferson			x	x			B			
				[28,41N,04E]				x	x			B			
				28,41N,4E											
Bell Cr.	C	6.0	Mouth	09,37N,12W	Pulaski			x	x				x		
Bell Fountain Ditch	P	18.0	29,16N,9E	12,16N,11E	Dunklin	Pemiscot		x	x			B			
Bellevu Cr.	C	5.1	Mouth	6,47N,4E	St. Charles			x	x			[B]	x		
Bellevue Cr.	C	1.5	32,35N,3E	Sur 21 13,35N,3E	Iron			x	x			B			
Ben Br.	C	1.0	Mouth	22,44N,8W	Osage			x	x			B			
Bender Cr.	P	4.3	Mouth	13,31N,9W	Texas			x	x			B			
Bender Cr.	C	3.4	[13,31N,9W]	5,31N,8W	Texas			x	x			B			
				18,31N,8W											
Bennett Cr.	C	2.5	Mouth	30,30N,6E	Wayne			x	x			B			
Bennett Hollow	C	1.8	Mouth	13,23N,15W	Ozark			x	x			B			
Bennett Springs Cr.	P	1.6	Mouth	Bennett Springs	[Laclede]	[Dallas]		x	x		x	B			
					Dallas										
Bennets Bayou	P	5.3	State Line	30,22N,10W	Ozark	Howell		x	x			B			
Bennets Bayou	C	3.0	30,22N,10W	16,22N,10W	Howell			x	x			B			
Bennetts R.	C	5.0	State Line	24,22N,10W	Howell			x	x			B			
Benton Br.	P	0.5	Mouth	11,34N,19W	Dallas			x	x			B			
Benton Br.	C	1.0	11,34N,19W	11,34N,19W	Dallas			x	x			B			
Benton Cr.	P	6.8	Mouth	29,36N,5W	Crawford			x	x			A			
Benton Cr.	C	2.0	29,36N,5W	31,36N,5W	Crawford			x	x			B			
Big Barren Cr.	C	23.4	Mouth	32,26N,2W	Ripley	Carter		x	x	x		A			
Big Berger Cr.	P	12.5	Mouth	26,45N,4W	Franklin			x	x			B			

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Big Berger Cr.	C	8.8	26,45N,4W	17,44N,4W	Franklin	Gasconade		x	x			B			
Big Blue Br.	P	0.8	Mouth	12,31N,9E	Bollinger			x	x			B			
Big Blue Br.	C	1.5	12,31N,9E	6,31N,10E	Bollinger			x	x			B			
Big Bottom Cr.	C	1.5	Mouth	Lake Anne	Ste. Genevieve			x	x				x		
Big Bottom Cr.	C	2.1	[Lake Anne] Mouth	[13,37N,07E] 13,37N,7E	Ste. Genevieve			x	x			B			
Big Br.	C	0.5	Mouth	22,43N,04W	Franklin			x	x			B			
Big Br.	C	2.8	Mouth	22,46N,11W	Callaway			x	x			B			
Big Branch	C	3.4	Mouth	23,44N,04W	Franklin			x	x			B			
Big Brushy Cr.	P	9.2	Mouth	9,27N,3E	Wayne	Carter		x	x			A			
Big Brushy Cr.	C	7.6	9,27N,3E	4,27N,2E	Carter			x	x			B			
Big Buffalo Cr.	P	5.6	Mouth	06,41N,19W	Benton	Morgan		x	x	x		B	x		
Big Buffalo Cr.	C	2.8	06,41N,19W	28,42N,19W	Morgan		x	x	x			B			
Big Cane Cr.	C	4.9	State Line	26,22N,5E	Butler		x	x	x			B			
Big Cr.	P	70.5	Mouth	34,47N,31W	Henry	Jackson		x	x			B			
Big Cr.	C	[3.3]/4.8	Mouth	[16,42N,31W] 8,42N,3W	Franklin			x	x				x		
Big Cr.	P	10.3	Mouth	25,48N,1W	Lincoln			x	x			A	x		
Big Cr.	C	17.7	25,48N,1W	8,47N,2W	Lincoln	Warren		x	x			B	x		
Big Cr.	C	2.0	Mouth	3,22N,25W	Barry			x	x			B			
Big Cr.	C	9.0	Mouth	25,23N,17W	Taney			x	x			A			
Big Cr.	P	23.0	Mouth	5,31N,2W	Shannon			x	x			A			
Big Cr.	C	28.7	Mouth	5,29N,8W	Shannon	Texas		x	x	x		B			
Big Cr.	P	34.1	Mouth	23,33N,3E	Wayne	Iron		x	x	x		A	x		
Big Cr.	C	0.8	23,33N,3E	23,33N,3E	Iron			x	x			B			
Big Cr.	C	4.3	34,47N,31W	20,47N,31W	Jackson			x	x			B			
Big Cr.	P	31.5	Mouth	9,63N,28W	Daviess	Harrison		x	x			B		x	
Big Cr.	C	1.5	9,54N,23W	17,54N,23W	Carroll			x	x			B			
Big Cr.	P	31.6	Mouth	9,54N,23W	Carroll			x	x			B			
Big Cr.	P	6.1	Mouth	29,31N,7E	Wayne	Madison		x	x			A			
Big Cr. Cutoff	C	1.5	Mouth	1,30N,3E	Iron			x	x			B			
Big Deer Cr.	C	[4.6]/5.7	Mouth	[27,42N,31W] 34,42N,31W	Bates			x	x			B			
Big George Br.	C	3.0	Mouth	18,32N,28W	Barton	Dade		x	x			B			
Big Gulch	C	2.2	Mouth	3,27N,11W	Douglas			x	x			B			
Big Hollow	C	3.2	Mouth	23,22N,21W	Taney			x	x			B			
Big Hollow Br.	C	2.0	Mouth	17,32N,10E	Bollinger			x	x			B			
Big Hunting Slough	C	15.9	Mouth	24,23N,6E	Butler			x	x			B			
Big Lake Bayou	C	[11.3]/9.8	Mouth	[23,27N,15E] 30,27N,16E	Mississippi			x	x			B			
Big Lake Bayou	C	1.0	25,27N,15E	24,27N,15E	Mississippi	Scott		x	x			B			
Big Lake Cr.	P	6.4	Mouth	19,28N,5E	Wayne			x	x			B			
Big Lake Cr.	C	4.4	19,28N,5E	36,29N,4E	Wayne			x	x			B			
Big Lead Cr.	C	5.0	27,50N,2W	18,50N,2W	Lincoln			x	x			B			
Big Muddy Cr.	P	8.0	Mouth	33,60N,27W	Daviess			x	x			B			
Big Muddy Cr.	C	12.0	33,60N,27W	09,61N,27W	Daviess			x	x				x		
Big Muddy Cr.	P	10.2	Mouth	11,64N,30W	Gentry			x	x			B			
Big Muddy Cr.	C	10.9	11,64N,30W	3,65N,29W	Gentry	Harrison		x	x			B			

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Big No Cr.	C	4.9	Mouth	26,63N,23W	Grundy			x	x			B			
Big Otter Cr.	C	2.0	Mouth	31,40N,25W	Henry			x	x			B	x		
Big Paddy Cr.	C	4.0	Mouth	32,33N,10W	Texas			x	x			B			
Big Piney R.	P	96.8	Mouth	16,29N,10W	Pulaski	Texas	x	x	x	x		A	x	x	
Big Piney R.	P	7.8	16,29N,10W	12,28N,11W	Texas			x	x			A	x	x	
Big Piney R.	P	0.2	Mouth	33,34N,10W	Pulaski			x	x			B	x		
Big R.	P	55.6	Mouth	Sur 3166,40N,3E	Jefferson		x	x	x	x		A	x		x
Big R.	P	81.3	Sur 3166, 40N,3E	12,35N,1E	Jefferson	Washington		x	x			A			x
Big R.	C	2.8	12,35N,1E	Council Bluff Lk. D.	Washington	Iron		x	x			B			
Big R.	C	2.0	Mouth	32,35N,1E	Iron			x	x			B			
Big River Cr.	C	0.7	Mouth	04,40N,05W	Gasconade			x	x			B			
Big Rock Cr.	C	5.9	8,65N,30W	36,66N,30W	Worth			x	x			B			
Big Rock Cr.	P	3.7	Mouth	8,65N,30W	Worth			x	x			B			
Big Sugar Cr.	P	39.3	Mouth	26,21N,29W	McDonald	Barry	x	x	x	x		A	x		
Big Sugar Cr.	C	4.9	26,21N,29W	20,21N,28W	Barry			x	x			B			
[Big Tavern Cr.]	C	3.2	Mouth	23,46N,7W	Callaway			x	x			B			
Tavern Cr.															
Bigelow's Cr.	C	5.0	Mouth	[15,44N,01E] 15,44N,1E	St. Charles		x	x				B	x		
Billies Cr.	C	6.6	Mouth	36,29N,25W	Lawrence			x	x			B			
Billy Cr.	C	5.5	Mouth	6,62N,16W	Adair			x	x			B			
Billys Br.	C	11.5	Mouth	19,59N,13W	Macon			x	x			B			
[Billy's Br.]	C	1.6	06,37N,01W	05,37N,01W	Washington			x	x			B			
Billys Br.															
[Billy's Br.]	P	2.4	Mouth	[06,37N,01W] 6,37N,1W	Crawford	Washington		x	x			B			
Billys Br.															
Birch Cr.	C	4.5	Mouth	6,42N,1E	Franklin			x	x			B	x		
Bird Br.	C	1.0	Mouth	14,41N,22W	Benton			x	x			B			
Birkhead Br.	C	2.0	Mouth	[17,49N,02E] 17,49N,2E	Lincoln			x	x				x		
Bitterroot Cr.	C	3.0	Mouth	30,37N,33W	Vernon			x	x			B			
Black Cr.	P	19.4	Mouth	29,58N,10W	Shelby			x	x			B			
Black Cr.	C	21.8	29,58N,10W	11,59N,12W	Shelby			x	x			B			
Black Cr.	C	7.3	Mouth	35,43N,32W	Cass			x	x			B			
Black Cr.	P	1.6	Mouth	21,45N,6E	St. Louis			x	x			B	x		
Black Jack Cr.	C	5.0	Mouth	16,47N,25W	Johnson			x	x			B			
Black R.	P	[26.9]/25.8	7,29N,3E	[17,32N,2E] 21,32N,2E	Reynolds		x	x	x	x		A	x		x
Black R.	P	47.1	State Line	16,25N,6E	Butler		x	x	x	x		A	x	x	
Black R.	P	39.0	16,25N,6E	Clearwater Dam	Butler	Wynne	x	x	x	x		A	x	x	
Black R. Ditch	P	11.1	State Line	32,23N,7E	Butler		x	x	x			B			
Blackberry Cr.	C	6.5	Mouth	28,30N,33W	Jasper			x	x			B			
Blackbird Cr.	P	9.4	Mouth	2,64N,17W	Adair	Putnam		x	x			A			
Blackwater R.	P	[79.4]/79.0	Mouth	12,46N,27W	Cooper	Johnson	x	x	x			A	x	x	
Blair Br.	P	1.5	Mouth	8,61N,8W	Lewis			x	x			B			
Blair Cr.	P	8.2	Mouth	31,30N,2W	Shannon			x	x			B			
Blair Cr.	C	4.3	31,30N,2W	18,30N,2W	Shannon			x	x			B			
Blair Hollow	C	1.5	Mouth	1,22N,12W	Ozark			x	x			B			

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Blay Cr.	C	2.0	Mouth	36,37N,3E	St. Francois	Washington		x	x			B			
Block Br.	P	0.6	Mouth	18,41N,04W	Gasconade			x	x			B			
Block Br.	C	1.6	18,41N,04W	11,41N,05W	Gasconade			x	x			B			
Bloom Cr.	C	3.0	Mouth	36,36N,7E	Ste. Genevieve			x	x			[B]	x		
Blue Cr.	P	1.5	Mouth	6,33N,9E	Bollinger			x	x			B			
Blue Cr.	C	1.0	6,33N,9E	7,33N,9E	Bollinger			x	x			B			
Blue Cr.	C	1.7	Mouth	31,46N,8W	Callaway			x	x			B			
Blue Cr.	P	1.8	Mouth	5,50N,17W	Howard			x	x			B			
Blue Cr.	C	2.6	5,50N,17W	4,50N,17W	Howard			x	x			B			
Blue Ditch	P	[5.8]/11.6	Mouth	[14,27N,14E] 29,28N,14E	Scott		x	x	x			B	x		
Blue Ditch	C	5.8	14,27N,14E	29,28N,14E	Scott		x	x	x			B	x		
Blue R.	P	4.4	Mouth	6,49N,32W	Jackson			x	x			B			x
Blue R.	P	9.4	6,49N,32W	2,48N,33W	Jackson			x	x			B	x		x
Blue R.	P	7.7	2,48N,33W	28,48N,33W	Jackson			x	x			A	x		
Blue R.	C	12.0	28,48N,33W	State Line	Jackson			x	x			B	x		
Blue Shawnee Cr.	P	1.6	8,33N,13E	17,33N,13E	Cape Girardeau			x	x			B			
Blue Shawnee Cr.	C	2.5	17,33N,13E	29,33N,13E	Cape Girardeau			x	x			B			
Blue Spring Cr.	P	1.5	Mouth	35,41N,16W	Miller			x	x			B			
Blue Spring Cr.	C	0.5	35,41N,16W	26,41N,16W	Miller			x	x			B			
Blue Spring Slough	C	15.8	34,24N,7E	35,26N,7E	Butler			x	x			B			
Blue Springs Cr.	P	4.3	Mouth	2,39N,3W	Crawford			x	x		x	A			
Blue Springs Cr.	C	1.2	2,39N,3W	3,39N,3W	Crawford			x	x			B			
Bluewater Cr.	C	1.5	Mouth	11,26N,6E	Wayne	Butler		x	x			B			
Blythes Cr.	P	6.9	Mouth	27,42,15W	Moniteau	Miller		x	x			B	x		
Bobs Cr.	P1	4.9	Mouth	[Sur 306,49N,2E] LG 306,49N,2E	Lincoln			x	x			B			
Bobs Cr.	P	1.7	Sur 306,49N,2E	34,49N,2E	Lincoln			x	x			B			
Bobs Cr.	C	14.2	34,49N,2E	27,50N,1E	Lincoln			x	x			B	x		
Boeuf Cr.	P	30.7	Mouth	22,43N,4W	Franklin		x	x	x			A			
Boeuf Cr.	C	8.5	[15,43N,4W] 22,43N,4W	5,42N,4W	Gasconade			x	x			B			
Boiling Spr. Hollow	C	1.5	Mouth	3,36N,1W	Washington			x	x			B			
Boiling Spring	P	0.1	Mouth	24,32N,10W	Texas			x	x			B			
Bois Brule Cr.	P	1.8	Mouth	20,42N,12W	Cole			x	x			B			
Bois Brule Cr.	C	9.5	20,42N,12W	20,42N,13W	Cole			x	x			B	x		
[Bois Brule Ditch]	P	4.7	Mouth	[16,36N,11E]	Perry			x	x			B	x		
Bois Brule Cr.	C	3.0	Mouth	LG 142,36N,11W 15,24N,12W	Ozark			x	x			B			
Bollinger Cr.	C	2.4	5,39N,18W	7,39N,18W	Camden			x	x			B			
Bones Br.	C	8.3	Mouth	29,41N,31W	Bates			x	x			B			
Benhomme Cr.	C	2.5	Mouth	Sur 2031,45N,4E	St. Louis			x	x			B			
Bonne Femme Cr.	P	24.0	Mouth	36,51N,16W	Howard			x	x			B			
Bonne Femme Cr.	P	7.8	Mouth	20,47N,12W	Boone			x	x			A			
Bonne Femme Cr.	C	7.0	20,47N,12W	2,47N,12W	Boone			x	x			B			
Bonne Femme Cr.	C	13.0	36,51N,16W	22,52N,15W	Howard	Randolph		x	x			B			
Boone Cr.	P	3.8	Mouth	16,32N,9W	Texas			x	x			B			
Boone Cr.	C	1.7	16,32N,9W	15,32N,9W	Texas			x	x			B			

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Boone Cr.	P	3.5	Mouth	29,41N,3W	Franklin			x	x			B			
Boone Cr.	C	8.0	29,41N,3W	15,40N,3W	Franklin			x	x			B	x		
Boones Br.	C	2.5	Mouth	5,49N,17W	Howard			x	x			B			
Bounds Cr.	C	2.2	Mouth	30,29N,6E	Wayne			x	x			B			
Bourbeuse R.	P	136.7	Mouth	4,39N,6W	Franklin	Phelps	x	x	x	x		A	x	x	
Bourbeuse R.	C	[11.1]/14.5	4,39N,6W	[12,38N,7W] 22,38N,7W	Phelps			x	x	x		[B]	x		
Bourne Cr.	P	1.9	Mouth	15,42N,4E	Jefferson			x	x			B			
Bradley Br.	C	2.2	Mouth	7,45N,26W	Johnson			x	x			B			
Brashear Hollow	C	0.9	Mouth	33,39N,15W	Camden			x	x			B			
Brawley Cr.	C	2.8	Mouth	26,45N,26W	Johnson			x	x			B	x		
Bray Hollow	C	1.0	Mouth	27,23N,15W	Ozark			x	x			B			
Brazeau Cr.	P	10.8	Mouth	17,34N,13E	Perry			x	x			B			
Brazil Cr.	P	13.9	Mouth	27,38N,1W	Crawford	Washington		x	x			A			
Brazil Cr.	C	1.8	27,38N,1W	26,38N,1W	Washington			x	x			B			
Brewer Lake	P	3.5	8,26N,18E	36,27N,17E	Mississippi			x	x			B			
Brewer Lake Ditch	C	[4.3]/4.9	[5,26N,18E] 29,26N,18E	[20,26N,18E] 5,26N,18E	Mississippi			x	x			B			
Brewers Cr.	P	2.5	Mouth	29,34N,5E	Madison			x	x			B			
Brewers Cr.	C	1.0	29,34N,5E	19,34N,5E	Madison			x	x			B			
Briar Cr.	C	6.4	Mouth	13,23N,1E	Ripley			x	x			B			
Brickley Hollow	C	0.8	Mouth	35,41N,21W	Benton			x	x			B			
Bridge Cr.	C	1.7	Mouth	36,55N,23W	Carroll			x	x			B			
Bridge Cr.	C	8.4	Mouth	7,65N,13W	Scotland	Schuyler		x	x			B			
Bridge Cr.	C	27.0	Mouth	13,63N,12W	Lewis	Knox		x	x			B	x		
Bridges Cr.	C	6.4	Mouth	17,22N,11W	Ozark			x	x			B			
Bright Hollow	C	2.0	Mouth	32,25N,20W	Taney	Christian		x	x			B			
Brixey Cr.	C	2.5	Mouth	17,24N,13W	Ozark			x	x			B			
Broadus Br.	C	2.1	Mouth	15,37N,18W	Camden			x	x			B			
Brock Cr.	P	3.2	Mouth	3,35N,1E	Washington			x	x			B			
Brock Cr.	C	1.5	3,35N,1E	4,35N,1E	Washington			x	x			B			
Browne Br.	C	1.8	Mouth	25,57N,9W	Marion	Shelby		x	x			B			
Browne Br.	C	0.7	Mouth	25,57N,9W	Shelby			x	x			B			
Browning Hollow	C	1.0	Mouth	20,26N,26W	Lawrence			x	x			B			
Browns Br.	C	2.5	Mouth	6,43N,1E	Franklin			x	x			B	x		
Browns Br.	C	3.7	6,43N,1E	[13,43N,01W] 14,43N,1W	Franklin			x	x			B			
Brush Cr.	C	[5.3]/6.3	Mouth	14,56N,10W	Monroe			x	x			B			
Brush Cr.	C	3.4	Mouth	2,53N,9W	Monroe			x	x			B			
Brush Cr.	C	0.8	Mouth	32,40N,17W	Camden			x	x			B			
Brush Cr.	P	2.2	Mouth	19,42N,23W	Henry	Benton		x	x			B			
Brush Cr.	C	2.3	Mouth	27,38N,25W	St. Clair	Polk		x	x			B			
Brush Cr.	P	12.2	Mouth	31,36N,24W	St. Clair			x	x	x		A			
Brush Cr.	P	4.7	31,36N,24W	16,35N,24W	St. Clair	Polk		x	x			B			
Brush Cr.	P	3.5	Mouth	18,42N,8W	Osage			x	x			B			
Brush Cr.	C	2.4	18,42N,8W	11,42N,9W	Osage			x	x			B			
Brush Cr.	P	6.5	Mouth	27,33N,16W	Laclede			x	x			B			
Brush Cr.	C	2.5	27,33N,16W	32,33N,16W	Laclede			x	x			B	x		

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Brush Cr.	C	2.5	Mouth	11,43N,2E	St. Louis	Franklin		x	x			B	x		
Brush Cr.	C	7.8	Mouth	10,49N,4W	Montgomery			x	x			B	x		
Brush Cr.	P	1.4	Mouth	3,40N,1W	Franklin			x	x			B			
Brush Cr.	C	2.0	3,40N,1W	10,40N,1W	Franklin			x	x			B			
Brush Cr.	C	1.3	Mouth	26,41N,6W	Gasconade			x	x			B			
Brush Cr.	P	[17.5]/17.8	Mouth	[Indian Lake Dam] 10,39N,5W	Gasconade	Crawford		x	x			A			
Brush Cr.	C	2.0	23,39N,5W	27,39N,5W	Crawford			x	x			B			
Brush Cr.	P	7.4	Mouth	11,25N,13W	Ozark	Douglas		x	x			B			
Brush Cr.	C	1.5	11,25N,13W	1,25N,13W	Douglas			x	x			B			
Brush Cr.	C	7.4	Mouth	8,51N,34W	Platte			x	x			B	x		
Brush Cr.	C	2.3	Mouth	24,28N,8E	Wayne			x	x			B			
Brush Cr.	C	8.0	19,42N,23W	35,43N,23W	Benton			x	x			B			
Brush Cr.	P	1.8	Mouth	[17,43N,10W] 17,43N,9W	Osage			x	x			B			
Brush Cr.	C	2.0	16,35N,24W	22,35N,24W	Polk			x	x			B			
Brush Cr.	C	5.9	Mouth	36,50N,27W	Lafayette			x	x			B			
Brush Cr.	C	4.5	Mouth	26,66N,25W	Mercer			x	x			B			
Brush Cr.	C	5.0	Mouth	8,65N,26W	Harrison			x	x			B			
Brush Cr.	C	26.3	Mouth	2,59N,17W	Chariton	Macon		x	x			B			
Brush Cr.	P	0.5	Mouth	27,43N,14W	Cole			x	x			B			
Brush Cr.	C	5.0	27,43N,14W	16,42N,14W	Cole	Miller		x	x			[B]	x		
Brush Cr.	C	8.6	Mouth	25,34N,21W	Polk			x	x			B	x		
[Brush Fk.]	C	1.4	Mouth	23,45N,06W	Gasconade			x	x			B			
Brushy Fl.															
Brushy Br.	C	1.5	Mouth	1,42N,6W	Gasconade			x	x			B			
Brushy Br.	C	1.8	Mouth	11,49N,7W	Callaway			x	x			B			
Brushy Cr.	P	1.4	Mouth	04,40N,20W	Benton			x	x			B			
Brushy Cr.	P	3.5	Mouth	5,30N,9W	Texas			x	x			B			
Brushy Cr.	C	3.8	5,30N,9W	14,30N,09W	Texas			x	x			B			
Brushy Cr.	C	3.0	Mouth	Sur 1708,51N,1W	Lincoln			x	x			B			
Brushy Cr.	C	3.0	Mouth	4,43N,2W	Franklin			x	x			B	x		
Brushy Cr.	C	1.9	Mouth	7,35N,9E	Ste. Genevieve			x	x			B			
Brushy Cr.	C	6.4	Mouth	31,24N,17W	Taney			x	x			B			
Brushy Cr.	P	3.0	Mouth	17,30N,3W	Shannon			x	x			B			
Brushy Cr.	C	1.6	17,30N,3W	16,30N,3W	Shannon			x	x			B			
Brushy Cr.	C	4.5	Mouth	25,33N,1W	Reynolds			x	x			B			
Brushy Cr.	P	3.0	Mouth	28,27N,4E	Wayne			x	x			A			
Brushy Cr.	C	1.9	28,27N,4E	30,27N,4E	Wayne			x	x			A			
Brushy Cr.	C	1.0	Mouth	34,31N,4E	Iron			x	x			B			
Brushy Cr.	C	12.1	Mouth	State Line	Nodaway	Worth		x	x			B			
Brushy Cr.	C	1.5	Mouth	27,46N,23W	Pettis			x	x			[B]	x		
Brushy Cr.	C	7.0	Mouth	18,54N,29W	Caldwell	Ray		x	x			B	x		
Brushy Cr.	C	0.5	32,46N,21W	5,45N,21W	Pettis			x	x			B			
Brushy Cr.	C	2.2	Mouth	1,52N,32W	Clay			x	x			B	x		
Brushy Cr.	C	5.4	Mouth	30,60N,26W	Daviess			x	x			B			
Brushy Cr.	C	[8.1]/13.4	Mouth	[8,57N,29W] 2,57N,30W	Caldwell			x	x			B	x		

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Brushy Cr.	C	4.5	Mouth	36,65N,14W	Schuyler			x	x			B			
Brushy Cr.	C	5.2	Mouth	7,46N,11W	Boone			x	x			B			
Brushy Cr.	P	3.8	Mouth	SW 32,46N,21W	Pettis			x	x			B			
Brushy Fk.	C	5.0	Mouth	12,39N,14W	Miller			x	x	x		A			
Brushy Fk.	C	1.0	Mouth	12,38N,1W	Washington			x	x			B			
Brushy Fk.	C	4.0	Mouth	21,49N,2E	Lincoln			x	x			/B/	x		
Brushy Hollow	C	1.0	Mouth	25,23N,15W	Ozark			x	x			B			
Brushy Hollow Br.	P	1.3	Mouth	Sur 430,37N,2E	Washington			x	x			B			
Bryant Cr.	P	16.4	Mouth	3,23N,12W	Ozark	Douglas		x	x	x		A	x		
Bryant Cr.	P	1.0	3,23N,12W	34,24N,12W	Ozark			x	x		x	A	x		
Bryant Cr.	P	44.8	34,24N,12W	17,27N,15W	Ozark	Douglas		x	x	x		A	x		
Bryants Cr.	C	0.2	28,51N,1E	28,51N,1E	Lincoln			x	x			B			
Bryants Cr.	C	/15.9/13.2	Mouth	28,51N,1E	Pike	Lincoln		x	x			B			
Buchler Cr.	P	1.4	Mouth	/14,42N,09W/	Osage			x	x			B			
Buck Br.	C	5.5	Mouth	14,42N,9W	Jasper			x	x			B			
Buck Cr.	C	1.5	Mouth	18,29N,31W	Osage			x	x			B			
Buck Cr.	C	1.0	Mouth	23,42N,8W	Jefferson			x	x			B			
Buck Cr.	P	4.0	Mouth	14,40N,5E	Bollinger			x	x			B			
Buck Cr.	C	1.2	24,33N,9E	14,33N,9E	Bollinger			x	x			B			
Buck Elk Br.	C	1.0	Mouth	24,33N,9E	Osage			x	x			B			
Buck Elk Cr.	P	1.5	Mouth	11,41N,8W	Osage			x	x			B			
Buck Elk Cr.	C	1.0	Mouth	9,41N,8W	Osage			x	x			B			
Buckeye Cr.	P	3.4	Mouth	10,41N,8W	Cape Girardeau			x	x			B			
Buckeye Cr.	C	/2.6/1.4	/Hwy 61/	14,33N,12E	Cape Girardeau			x	x			B			
Bucklick Cr.	C	5.4	Mouth	22,33N,12E	Franklin			x	x			B			
Buffalo Cr.	P	/3.4/3.1	Mouth	30,44N,2W	Pike			x	x			B			
Buffalo Cr.	C	3.7	5,53N,1W	5,53N,1W	Pike			x	x			B			
Buffalo Cr.	P	5.4	Mouth	19,53N,1W	Ripley			x	x	x		B			
Buffalo Cr.	P	10.7	State Line	20,24N,1E	McDonald			x	x	x	x	A	x		
Buffalo Cr.	P	8.0	/5,23N,33W/	14,24N,33W	McDonald	Newton		x	x	x	x	A	x		
Buffalo Cr.	C	1.7	Mouth	12,24N,33W	Newton			x	x			B			
Buffalo Cr.	C	2.1	Mouth	28,48N,22W	Saline	Pettis		x	x			B			
Buffalo Ditch	P	17.3	State Line	11,18N,9E	Dunklin			x	x			B			
Buffalo Ditch	C	3.0	11,18N,9E	36,19N,9E	Dunklin			x	x			B			
Bull Cr.	P	5.0	Mouth	34,24N,21W	Taney			x	x	x	x	A	x		
Bull Cr.	P	18.9	34,24N,21W	33,26N,20W	Taney	Christian		x	x	x	x	A	x		
Bull Cr.	C	3.2	33,26N,20W	22,26N,20W	Christian			x	x			A			
Bullskin Cr.	P	4.9	Mouth	26,24N,32W	McDonald	Newton		x	x	x		B			
Buncomb Br.	C	1.2	Mouth	25,48N,23W	Pettis			x	x			B			
Burgher Br.	C	1.5	Mouth	07,37N,07W	Phelps			x	x			B	x		
Burkhart Br.	C	3.7	Mouth	12,31N,12W	Texas			x	x			B			
Burney Br.	C	4.5	Mouth	21,31N,24W	Dade	Greene		x	x			B			
Burr Oak Cr.	C	6.8	Mouth	19,49N,31W	Jackson			x	x			B			
Burr Oak Cr.	C	2.0	Mouth	33,54N,25W	Carroll			x	x			B			
Burris Fk.	C	8.0	10,43N,16W	25,43N,17W	Moniteau	Morgan		x	x			B			

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Burris Fk.	P	13.2	Mouth	10,43N,16W	Moniteau		x	x				A	x		
Burton Br.	C	2.0	Mouth	13,31N,10W	Texas		x	x				B			
Busch Cr.	C	2.0	Mouth	23,44N,1W	Franklin		x	x				B	x		
Butcher Br.	P	1.4	Mouth	12,40N,03E	Jefferson		x	x				B			
Butcher Cr.	C	1.0	Mouth	15,48N,1E	Lincoln		x	x				B			
Butler Cr.	C	4.0	State Line	17,21N,27W	Barry		x	x				B			
Butler Cr.	P	3.9	Mouth	State Line	McDonald		x	x	x	x		A			
Bynum Cr.	C	5.9	Mouth	16,49N,9W	Callaway		x	x				B			
Byrd Cr.	P	14.6	Mouth	Sur 325,32N,12E	Cape Girardeau		x	x				B			
Byrd Cr.	C	1.5	Sur 325,32N,12E	33,33N,12E	Cape Girardeau		x	x				B			
Cabanne Course	C	1.5	Mouth	3,37N,4E	St. Francois		x	x				B			
Cache R. Ditch	C	7.7	State Line	36,23N,7E	Butler		x	x	x			B			
Cadet Cr.	P	2.1	Mouth	34,44N,10W	Osage		x	x				B			
Cadet Cr.	C	1.0	34,44N,10W	26,44N,10W	Osage		x	x				B			
Cadet Cr.	P	2.0	Mouth	27,38N,3E	Washington		x	x				B			
Caloockie Cr.	C	4.0	Mouth	9,36N,20W	Dallas		x	x				B			
Calico Cr.	C	5.4	Mouth	02,39N,02E	Jefferson	Washington	x	x				A			
California Br.	C	2.7	Mouth	17,40N,1E	Franklin	Washington	x	x				B			
Callahan Cr.	C	13.8	Mouth	23,50N,14W	Boone		x	x					x		
Callaway Fk.	C	4.5	Mouth	6,45N,2E	St. Charles		x	x				B			
Calton Cr.	C	5.5	Mouth	16,25N,26W	Barry		x	x				B	x		
Calumet Cr.	P	[1.8]/1.6	Mouth	18,53N,1E	Pike		x	x				B			
Calumet Cr.	C	4.0	18,53N,1E	26,53N,1W	Pike		x	x				B	x		
Calvey Cr.	P	3.0	Mouth	4,42N,2E	Franklin		x	x				B			
Calvey Cr.	C	4.5	4,42N,2E	13,42N,2E	Franklin		x	x				B	x		
Camp Br.	C	16.1	Mouth	33,45N,30W	Johnson	Cass	x	x				B	x		
Camp Br.	C	7.3	Mouth	20,39N,29W	Bates		x	x				B			
Camp Br.	C	4.0	Mouth	27,48N,3W	Warren		x	x				B	x		
Camp Br.	C	4.2	Smithville Lk	36,54N,32W	Clay		x	x				B			
Camp Br.	C	3.5	Mouth	35,29N,10W	Texas		x	x					x		
Camp Br.	C	10.1	Mouth	24,45N,23W	Pettis		x	x				B			
Camp Cr.	C	3.2	Mouth	23,38N,9W	Phelps		x	x				B			
Camp Cr.	P	[6.3]/6.7	Mouth	26,49N,3W	Lincoln	Warren	x	x				B			
Camp Cr.	C	6.0	26,49N,3W	16,48N,3W	Warren		x	x				B			
Camp Cr.	C	1.0	Mouth	16,25N,21W	Christian		x	x				B			
Camp Cr.	P	5.3	Mouth	34,30N,4E	Wayne		x	x				B			
Camp Cr.	C	1.3	34,30N,4E	33,30N,4E	Wayne		x	x				B			
Camp Cr.	C	[2.0]/2.0	[28,36N,6E]	[29,36N,06E]	St. Francois		x	x				B			
Camp Cr.	C	5.5	Mouth	24,50N,20W	Saline		x	x				B			
Campbell Br.	C	2.3	Mouth	7,48N,2E	Lincoln		x	x				B			
Campbell Cr.	C	2.8	Mouth	19,61N,30W	Gentry		x	x							
Campbell Cr.	C	5.9	Mouth	24,56N,23W	Livingston		x	x				B			
Cane Cr.	P	8.7	Mouth	Sur 3146,32N,12E	Cape Girardeau		x	x				B			
Cane Cr.	C	[4.0]/5.2	[Sur 3146,32N,12E]	7,32N,13E	Cape Girardeau		x	x				B	x		
LG 3146,32N,12E															

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Cane Cr.	C	4.0	Mouth	28,23N,18W	Taney			x	x	x		B			
Cane Cr.	P	27.5	30,23N,6E	5,25N,5E	Butler		x	x	x	x		A	x		
Cane Cr.	C	15.9	5,25N,5E	15,26N,3E	Butler	Carter		x	x	x		A			
Cane Cr.	C	9.8	Mouth	30,23N,6E	Butler		x	x	x			B			
Cane Cr.	C	3.6	6,29N,10E	27,30N,9E	Bollinger			x	x			B			
Cane Cr.	P	8.4	Mouth	6,29N,10E	Bollinger			x	x			B			
Cane Cr. Ditch	P	7.5	State Line	30,23N,6E	Butler		x	x	x			B	x		
Caney Cr.	C	3.0	Mouth	11,24N,17W	Taney			x	x			A			
Caney Cr.	C	7.0	Mouth	5,23N,13W	Ozark			x	x			B			
Caney Cr.	C	11.5	[9,28N,12E] Mouth	36,29N,13E	Scott			x	x				x		
Caney Fk.	P	5.3	Mouth	3,32N,11E	Cape Girardeau			x	x			B			
Caney Fk.	C	4.0	3,32N,11E	28,33N,11E	Cape Girardeau			x	x			B			
Cannon Br.	P	0.8	Mouth	17,36N,25W	St. Clair			x	x			B			
Cantrell Cr.	P	7.8	Mouth	07,30N,16W	Webster			x	x			B			
Cantrell Cr.	C	5.9	07,30N,16W	32,30N,16W	Webster			x	x			B			
Cape Cr.	P	1.0	Mouth	22,33N,8E	Madison			x	x			B			
Cape Cr.	C	0.5	22,33N,8E	22,33N,8E	Madison			x	x			B			
Cape La Croix Cr.	P	[7.2/10.2	Mouth	[Sur 3314,31N,13E] 12,31N,13E	Cape Girardeau			x	x			B			
Cape La Croix Cr.	C	1.6	12,31N,13E	2,13N,13E	Cape Girardeau			x	x			B	x		
Capps Cr.	P	5.0	Mouth	17,25N,28W	Newton	Barry	x	x	x		x	A	x		
Captain Cr.	C	[1.0/1.2	Mouth	24,32N,5E	Madison			x	x			B			
Carney Cr.	C	4.5	Mouth	3,24N,25W	Barry			x	x			B	x		
Carr Br.	C	0.3	Mouth	3,54N,8W	Monroe			x	x			B			
Carroll Cr.	C	9.4	Mouth	[04,53N,30W] 4,53N,30W	Clay			x	x			B			
Carter Cr.	C	1.0	Mouth	5,39N,2W	Crawford			x	x			B			
Carter Cr.	C	6.0	Mouth	4,27N,1E	Carter			x	x			B			
Carver Br.	P	3.0	Mouth	13,26N,32W	Newton			x	x			A			
Carver Cr.	P	1.6	Mouth	28,32N,3E	Iron			x	x			B			
Carver Cr.	C	4.0	28,32N,3E	16,32N,3E	Iron			x	x			B			
Casmer Br.	C	1.5	Mouth	12,48N,2W	Lincoln			x	x			B			
Cason Br.	C	2.5	Mouth	21,45N,10W	Callaway			x	x						
Castile Cr.	C	40.2	Mouth	24,58N,32W	Buchanan	DeKalb		x	x			B	x	x	
Casto Cr.	C	4.3	Mouth	14,27N,16W	Douglas			x	x			B			
Castor R.	P	45.5	Mouth	31,28N,10E	Stoddard			x	x			B			
Castor R.	C	10.5	31,28N,10E	12,28N,9E	Stoddard	Bollinger		x	x			B			
Castor R.	P	7.5	12,28N,9E	29,29N,9E	Bollinger		x	x	x			A	x		
Castor R.	P	[59.0/59.6	29,29N,9E	19,34N,8E	Bollinger	Madison		x	x	x		A	x		
Castor R.	C	2.5	19,34N,8E	7,34N,8E	Madison	St. Francois		x	x			B			
Castor R. Div. Chan.	P	12.2	4,29N,11E	12,28N,9E	Cape Girardeau	Bollinger		x	x			A	x	x	
Castro Valley	C	3.4	Mouth	1,29N,6W	Shannon			x	x			B			
Cat Br.	P	2.3	Mouth	3,57N,12W	Shelby			x	x			B			
Cat Br.	C	2.9	3,57N,12W	15,57N,12W	Shelby			x	x			B			
Cat Hollow	C	2.5	Mouth	33,35N,18W	Dallas			x	x			B			
Cathcart Hollow	C	1.8	Mouth	20,31N,09W	Texas			x	x			B			

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Cato Slough	C	5.7	[Mouth] 34,28N,9E	15,28N,9E	Bollinger		x	x	x			B			
Caulks Cr.	P	6.2	Mouth	30,45N,4E	St. Louis			x	x			B	x		
Caulks Cr.	C	3.3	30,45N,4E	12,44N,3E	St. Louis			x	x			B	x		
Cave Br.	C	2.7	Mouth	13,36N,27W	Cedar			x	x			B			
Cave Cr.	C	3.2	Mouth	14,34N,18W	Dallas			x	x			B			
Cave Cr.	C	0.5	Mouth	29,48N,15W	Cooper			x	x			B			
Cave Fk.	C	3.4	Mouth	10,24N,1W	Ripley			x	x			B			
Cave Spring Br.	C	1.2	16,28N,29W	21,28N,29W	Jasper			x	x			B			
Cave Spring Cr.	C	1.2	Mouth	5,43N,33W	Cass			x	x			B			
Cave Spring Hollow	C	1.5	Mouth	12,29N,2E	Reynolds			x	x			B			
Cedar Bottom Cr.	P	3.5	Mouth	32,33N,6E	Madison			x	x			B			
Cedar Bottom Cr.	C	3.0	32,33N,6E	10,32N,6E	Madison			x	x			B			
Cedar Br.	P	2.7	Mouth	16,31N,10E	Bollinger			x	x			B			
Cedar Br.	C	1.7	16,31N,10E	8,31N,10E	Bollinger			x	x			B			
Cedar Cr.	P	31.0	Mouth	20,34N,27W	Cedar		x	x	x			A	x		
Cedar Cr.	C	16.2	20,34N,27W	10,32N,28W	Cedar	Dade		x	x			B			
Cedar Cr.	C	2.0	Mouth	15,42N,6W	Groesbeke			x	x			B	x		
Cedar Cr.	P	11.3	Mouth	[34,35N,2E] LG 2184,35N,2E	Washington	Iron		x	x			A			
Cedar Cr.	C	2.6	[Sur 2184,35N,2E] LG 2184,35N,2E	5,34N,2E	Iron			x	x			B			
Cedar Cr.	C	2.8	2,22N,19W	6,22N,18W	Taney			x	x			B			
Cedar Cr.	P	6.5	Mouth	11,30N,6E	Wayne			x	x			B			
Cedar Cr.	P	2.2	Mouth	28,26N,32W	Newton			x	x			B			
Cedar Cr.	C	4.3	Mouth	12,47N,32W	Jackson			x	x			B			
Cedar Cr.	C	4.9	Mouth	[34,40N,08W] 34,40N,8W	Maries			x	x			[B]	x		
Cedar Cr.	C	37.4	21,46N,11W	3,49N,11W	Callaway			x	x			B	x		
Cedar Cr.	P	14.0	Mouth	21,46N,11W	Callaway			x	x			B	x		
Cedar Cr.	P	7.5	Mouth	20,44N,8W	Osage			x	x			B	x		
Cedar Cr.	C	4.7	20,44N,8W	3,43N,8W	Osage			x	x			B			
Cedar Cr.	C	3.3	Mouth	26,46N,21W	Pettis			x	x			B			
Cedar Fk.	C	8.8	Mouth	18,43N,3W	Franklin			x	x			B			
Cedar Fk.	P	3.4	Mouth	[9,35N,9E] LG 3137,35N,9E	Perry			x	x			B			
Cedar Fk.	C	1.2	[9,35N,9E] LG 3137,35N,9E	16,35N,9E	Perry			x	x			B			
Cedar Run	C	1.1	Mouth	21,37N,05E	St. Francois			x	x			B			
Center Cr.	P	26.8	14,28N,34W	34,28N,31W	Jasper		x	x	x	x		A	x		x
Center Cr.	P	21.0	34,28N,31W	23,27N,29W	Jasper	Newton	x	x	x			A	x		x
Center Cr.	P	4.9	23,27N,29W	17,27N,28W	Newton	Lawrence	x	x	x		x	A	x		x
Center Cr.	P	4.5	17,27N,29W	26,27N,28W	Lawrence			x	x			A			
Chaney Br.	C	4.0	Mouth	6,32N,28W	Barton	Dade		x	x			B			
Chapel Cr.	C	2.0	Mouth	[Sur 2149,33N,6E] LG 2149,33N,6E	Madison			x	x			B			
Chapman Br.	C	1.9	Mouth	33,64N,32W	Gentry			x	x			B			

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Chariton R.	P	111.0	Mouth	State Line	Chariton	Putnam	x	x	x			A	x		
Charleton Hollow	P	0.3	5,23N,33W	4,23N,33W	McDonald			x	x			B			
Charrette Cr.	P	13.0	Mouth	14,45N,2W	Warren			x	x			A			
Charrette Cr.	P	7.5	14,45N,2W	24,46N,2W	Warren			x	x			A			
Charrette Cr.	C	4.8	24,46N,2W	8,46N,1W	Warren			x	x			B	x		
Chat Cr.	C	2.1/2.4	11,26N,26W	7,26N,25W	Lawrence			x	x			B	x		
Cheese Cr.	C	4.7	Mouth	09,43N,21W	Pettis	Benton		x	x			B			
Cherry Valley Cr.	C	3.2	Mouth	10,37N,3W	Crawford			x	x			B			
[Chesapeake Cr.]	P	3.2	Mouth	29,28N,25W	Lawrence			x	x		x	B			
Chesapeake Br.															
Chute of Island No.7	C	1.4	26,23N,16E	36,23N,16E	Mississippi		x	x	x			B			
Cicero Cr.	P	1.0	Mouth	9,38N,1W	Washington			x	x			B			
Cinque Hommes Cr.	P	17.1	Mouth	28,35N,11E	Perry			x	x			B			
Cinque Hommes Cr.	C	5.0	28,35N,11E	36,35N,10E	Perry			x	x			B	x		
Clabber Cr.	C	3.0	Mouth	14,45N,9W	Callaway			x	x			B			
Clammer Br.	C	1.0	Mouth	8,38N,27W	St. Clair			x	x			B			
[Clark Br.]	C	8.6	Mouth	29,56N,18W	Chariton			x	x			B			
Clarks Cr.															
Clark Cr.	P	5.0	Mouth	12,29N,14W	Wright			x	x			B			
Clark Cr.	C	5.6	12,29N,14W	3,28N,14W	Wright			x	x			B			
Clark Cr.	P	11.1	Mouth	20,29N,4E	Wayne			x	x	x		B			
Clark Cr.	C	1.5	20,29N,4E	29,29N,4E	Wayne			x	x			B			
Clark Fk.	C	8.3	Mouth	15,47N,16W	Cooper			x	x			B			
Clark Fk.	P	1.0	Mouth	15,43N,13W	Cole			x	x			B			
Clark Fk.	C	6.0	15,43N,13W	34,43N,13W	Cole			x	x			B			
Clayton Br.	P	2.0	Mouth	20,34N,1E	Iron			x	x			B			
Clayton Br.	C	1.4	20,34N,1E	18,34N,1E	Iron			x	x			B			
Clayton Hollow	C	1.0	Mouth	3,24N,18W	Taney			x	x			B			
Clear Cr.	C	4.7	Mouth	27,56N,10W	Monroe			x	x			B			
Clear Cr.	C	4.8	Mouth	27,42N,23W	Benton			x	x			B			
Clear Cr.	C	4.0	Mouth	11,44N,30W	Cass			x	x			B			
Clear Cr.	P	28.2	Mouth	10,35N,29W	St. Clair	Vernon		x	x			A			
Clear Cr.	C	22.3	10,35N,29W	[16,34N,30W]	Vernon			x	x			B			
Clear Cr.	P	15.2	Mouth	28,34N,30W	Greene			x	x			B			
Clear Cr.	C	4.3	Mouth	4,29N,23W	Montgomery			x	x			B			
Clear Cr.	C	1.6	Mouth	5,47N,5W	Washington			x	x			B			
Clear Cr.	C	2.0/3.5	Mouth	[16,39N,6W]	Phelps			x	x			B			
Clear Cr.	C	4.4	Mouth	22,39N,6W	Washington			x	x			B			
Clear Cr.	P	4.2	Mouth	17,39N,2E	Washington			x	x			B			
Clear Cr.	C	2.4	19,36N,2E	13,36N,1E	Washington			x	x			B			
Clear Cr.	C	13.0	Mouth	State Line	Nodaway			x	x			B			
Clear Cr.	P	11.1	Mouth	28,26N,28W	Newton	Lawrence		x	x			B			
Clear Cr.	C	3.5	28,26N,28W	36,26N,28W	Lawrence	Barry		x	x			B			
Clear Cr.	P	5.0	Mouth	26,53N,31W	Clay			x	x			B			
Clear Cr.	C	13.5	[6,53N,31W]	09,54N,31W	Clay	Clinton		x	x			[B]	x		
Clear Cr.	C	6.0	Mouth	26,53N,31W	Daviess			x	x			B			

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Clear Cr.	C	3.3	Mouth	10,57N,5W	Marion			x	x			B			
Clear Cr.	C	5.5	Mouth	22,47N,19W	Cooper			x	x			B			
Clear Fk.	C	1.5	Mouth	32,42N,6W	Gasconade			x	x			B			
Clear Fk.	C	7.0	Mouth	36,49N,6W	Montgomery			x	x			B			
Clear Fk.	P	25.8	Mouth	26,45N,25W	Johnson			x	x			B	x		
Clear Fk.	C	10.1	26,45N,25W	18,44N,24W	Johnson			x	x			B			
Clear Spring	P	0.3	Mouth	19,28N,08W	Texas			x	x			B			
Cliffy Br.	C	2.3	Mouth	36,44N,15W	Moniteau			x	x			B			
Clifton Cr.	C	5.5	Mouth	10,45N,11W	Callaway			x	x			B	x		
Clifty Cr.	C	11.4	Mouth	16,27N,12W	Douglas			x	x			B			
Clifty Hollow Cr.	C	2.9	Mouth	11,38N,10W	Maries			x	x			B			
Clubb Cr.	P	3.7	Mouth	2,29N,9E	Bollinger		x	x	x			B			
Clubb Cr.	C	2.1	2,29N,9E	33,30N,9E	Bollinger			x	x			B			
Coakley Hollow	C	1.6	Mouth	9,38N,15W	Camden			x	x			B			
Coal Cr.	P	/5.8/3.5	Mouth	/35,42N,26W/	Henry			x	x			B			
				2,41N,26W											
Coal Cr.	C	2.0	Mouth	1,65N,26W	Harrison			x	x			B			
Coalbank Cr.	C	1.8	Mouth	27,47N,17W	Cooper			x	x			B			
Coates Br.	P	3.0	Mouth	36,32N,24W	Polk			x	x			B			
Coatney Cr.	P	2.0	Mouth	15,36N,19W	Dallas			x	x			B			
Cobb Cr.	P	2.1	Mouth	21,33N,14W	Laclede			x	x			B			
Cobb Cr.	C	2.3	21,33N,14W	32,33N,14W	Laclede			x	x			B			
Coffman Hollow	C	1.0	Mouth	14,37N,1W	Washington			x	x			B			
Coldwater Cr.	C	4.6	34,44N,33W	8,43N,33W	Cass			x	x			B			
Coldwater Cr.	C	/6.9/7.9	Mouth	/13,47N,6E/	St. Louis			x	x			B			x
				LG 1202,47N,6E											
Coldwater Cr.	P	4.3	Mouth	27,35N,8E	Ste. Genevieve			x	x			B			
Coldwater Cr.	C	0.9	27,35N,8E	33,35N,8E	Ste. Genevieve			x	x			B			
Cole Camp Cr.	P	18.1	Mouth	/07,42N,21W/	Benton			x	x	x		B			
				7,42N,21W											
Cole Camp Cr.	C	4.8	07,42N,21W	26,43N,21W	Benton			x	x			B	x		
Cole Cr.	C	1.5	Mouth	4,45N,5W	Gasconade			x	x			B			
Cole Cr.	C	2.0	Mouth	17,51N,14W	Howard			x	x			B			
Cole Cr.	C	5.7	Mouth	Sur 3280,47N,4E	St. Charles			x	x			B			
Collier Cr.	C	1.5	Mouth	10,30N,5E	Wayne			x	x			B			
Collier Cr.	C	2.5	Mouth	18,45N,8W	Callaway			x	x			B			
Compton Br.	C	1.7	Mouth	16,36N,1E	Washington			x	x			B			
Constock Cr.	P	1.0	Mouth	34,34N,33W	Vernon			x	x			B			
Constock Cr.	C	7.5	34,34N,33W	8,33N,32W	Barton			x	x			B			
Conner Cr.	C	5.0	Mouth	5,46N,11W	Boone			x	x			B			
Conns Cr.	C	/2.0/2.8	20,37N,14W	26,37N,14W	Camden			x	x			B			
Conrad Cr.	P	3.2	Mouth	5,33N,9E	Bollinger			x	x			B			
Conrad Cr.	C	1.5	5,33N,9E	1,33N,8E	Bollinger			x	x			B			
Contrary Cr.	P	1.5	Mouth	13,43N,7W	Osage			x	x			B			
Contrary Cr.	C	4.5	13,43N,7W	9,43N,7W	Osage			x	x			B			
Contrary Cr.	C	10.0	Mouth	30,56N,35W	Buchanan			x	x			B			
Cook Hollow	C	2.0	Mouth	35,25N,21W	Taney	Christian		x	x			B			
Coon Cr.	C	3.6	Mouth	24,51N,14W	Boone			x	x			B			

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Coon Cr.	C	11.8	Mouth	08,53N,13W	Monroe	Randolph		x	x			B			
Coon Cr.	P	1.9	Mouth	22,30N,14W	Wright			x	x			B			
Coon Cr.	C	1.6	22,30N,14W	17,30N,14W	Wright			x	x			B			
Coon Cr.	C	13.2	Mouth	10,50N,6W	Montgomery			x	x			B	x		
Coon Cr.	C	[9.2/9.4	Mouth	[Hwy. 47] 4,48N,2W	Lincoln			x	x			B			
Coon Cr.	C	5.1	Mouth	24,22N,21W	Taney			x	x			B			
Coon Cr.	C	7.5	Mouth	14,30N,30W	Barton	Jasper		x	x			B			
Coon Cr.	C	12.2	Mouth	5,29N,28W	Dade	Lawrence		x	x			B			
Coon Cr.	C	5.8	Mouth	16,45N,22W	Pettis			x	x			B			
[Coon Hollow]	C	1.6	Mouth	3,34N,2E	Iron			x	x			B			
McClurg Br.															
Coon Hollow	C	4.4	Mouth	14,28N,07W	Texas			x	x			B			
Cooney Cr.	C	0.8	Mouth	11,40N,20W	Benton			x	x			B			
Coonville Cr.	C	1.3	Mouth	30,38N,5E	St. Francois			x	x			B			
Cooper Cr.	P	0.9	Mouth	07,22N,21W	Taney			x	x			B			
Cooper Cr.	C	1.1	07,22N,21W	06,22N,21W	Taney			x	x			B			
[Coopers Cr.]	C	7.3	Mouth	6,39N,26W	Henry	St. Clair		x	x			B			
Cooper Cr.															
Coppedge Cr.	C	1.2	Mouth	35,39N,7W	Maries			x	x			B			
Corn Cr.	C	1.1	Mouth	[36,36N,09W] 36,36N,9W	Phelps			x	x			B			
Cotter Cr.	C	1.5	Mouth	23,40N,4E	Jefferson			x	x			B	x		
[Cotton Wood Cr.]	C	3.5	Mouth	3,54N,18W	Chariton			x	x			B			
Cottonwood Cr.															
Cottonwood Cr.	C	2.0	Mouth	28,36N,33W	Vernon			x	x			B			
Cottonwood Cr.	C	3.9	Mouth	7,50N,25W	Lafayette			x	x			B			
Cottonwood Cr.	C	4.3	Mouth	5,56N,27W	Caldwell			x	x			B			
Cottonwood Cr.	C	2.4	Mouth	2,55N,25W	Livingston	Carroll		x	x			B			
Courtois Cr.	P	32.0	Mouth	17,35N,1W	Crawford	Washington		x	x	x		A	x		
Courtois Cr.	C	1.7	17,35N,1W	21,35N,1W	Washington	Iron		x	x	x		B			
Cow Br.	C	4.4	Mouth	29,65N,40W	Atchison			x	x			B			
Cow Cr.	C	2.5	Mouth	26,47N,8W	Callaway			x	x					x	
Cow Cr.	C	1.8	Mouth	25,51N,21W	Saline			x	x			B			
Cowskin Cr.	P	5.0	Mouth	33,27N,16W	Douglas			x	x			B			
Cowskin Cr.	C	3.6	[33,27N,16W] Mouth	16,27N,16W	Douglas			x	x			B			
Cox Br.	C	2.2	Mouth	10,38N,7W	Phelps			x	x			B	x		
Crabapple Cr.	C	3.8	Mouth	4,55N,27W	Caldwell			x	x			B			
Crabtree Br.	P	1.5	Mouth	18,34N,25W	Cedar			x	x			B			
Crabtree Br.	C	1.5	18,34N,25W	19,34N,25W	Cedar			x	x			B			
Cracked Neck Cr.	P	3.0	Mouth	6,29N,26W	[Lawrence] Dade	Lawrence		x	x			B			
Crane Cr.	P	8.4	Mouth	09,36N,21W	Hickory			x	x			B			
Crane Cr.	C	3.4	09,36N,21W	12,36N,21W	Hickory			x	x			B			
Crane Cr.	P	5.9	Mouth	8,25N,23W	Stone			x	x			A	x		
Crane Cr.	P	13.2	8,25N,23W	19,26N,24W	Stone			x	x		x	A	x		
Crane Pond Cr.	P	12.7	Mouth	33,32N,4E	Wayne	Iron		x	x			B			
Crane Pond Cr.	C	1.0	Mouth	33,32N,4E	Iron			x	x			B			

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Craven Ditch	C	11.6	Mouth	16,24N,6E	Butler		x	x	x				x		
Crawford Cr.	C	5.0	Mouth	32,46N,29W	Cass			x	x			B			
Creve Coeur Cr.	P	2.1	Mouth	Creve Coeur Lake	St. Louis			x	x			B			
Creve Coeur Cr.	C	3.8	Creve Coeur Lk	6,45N,5E	St. Louis			x	x			B			
Crider Cr.	P	4.7	Mouth	30,42N,6W	Gasconade			x	x			B			
Crider Cr.	C	3.4	30,42N,6W	2,41N,7W	Gasconade	Osage		x	x			B			
Crooked Br.	C	1.0	Mouth	22,24N,11W	Ozark			x	x			B			
Crooked Br.	C	3.1	Mouth	31,45N,30W	Cass			x	x			B			
Crooked Cr.	C	31.4	Mouth	1,56N,12W	Monroe	Shelby		x	x			B			
Crooked Cr.	C	4.0	Mouth	15,50N,5W	Montgomery			x	x			B			
Crooked Cr.	P	19.7	Mouth	36,35N,4W	Crawford	Dent		x	x	x		A			
Crooked Cr.	C	1.0	36,35N,4W	6,34N,3W	Dent			x	x			B			
Crooked Cr.	P	[3.5]/9.3	Mouth	[33,35N,2W]	Crawford			x	x	x		A			
				11,34N,2W		Iron									
[Crooked Cr.]	[P]	[1.5]	[Mouth]	[10,48N,1E]	[Lincoln]			[x]	[x]			[B]			
Crooked Cr.	C	7.0	10,48N,1E	11,48N,1W	Lincoln			x	x			B	x		
Crooked Cr.	C	2.8	Mouth	12,59N,33W	DeKalb			x	x			B			
Crooked Cr.	C	4.0	Mouth	12,60N,34W	Andrew			x	x			B			
Crooked Cr.	C	5.3	Mouth	06,44N,23W	Johnson	Pettis		x	x			B			
Crooked Cr.	C	2.3	Mouth	30,59N,23W	Livingston			x	x			B			
Crooked Cr.	P	44.8	Mouth	17,32N,9E	Cape Girardeau	Bollinger	x	x	x			A	x		
Crooked Cr.	C	1.0	17,32N,9E	8,32N,9E	Bollinger			x	x			B			
Crooked R.	P	58.1	Mouth	3,54N,29W	Ray			x	x			B			
Crooked R.	C	7.5	3,54N,29W	25,55N,30W	Ray	Clinton		x	x			B			
Crossville Br.	C	2.0	Mouth	28,33N,3W	Reynolds			x	x			B			
Crows Cr.	C	1.8	Mouth	3,39N,2W	Crawford			x	x			B			
Crows Fork Cr.	C	12.7	Mouth	35,48N,9W	Callaway			x	x			B			
Cub Cr.	P	6.6	Mouth	13,35N,1W	Washington			x	x			B			
Cub Cr.	C	1.0	13,35N,1W	18,35N,1E	Washington			x	x			B			
Cuivre R.	PI	11.6	Mouth	[Sur 1795,48N,2E]	St. Charles			x	x			B	x		
				LG 1795,48N,2E											
Cuivre R.	P	30.0	Sur 1795,48N,2E	14,49N,1W	St. Charles	Lincoln		x	x			A	x		
Cuivre Slough	P	4.0	Mouth	LG 1652,48N,3E	St. Charles	Lincoln		x	x			B	x		
Current R.	P	124.0	State Line	24,31N,6W	Ripley	Shannon	x	x	x	x		A	x		
Current R.	P	[18.8]/19.0	24,31N,6W	Montauk Spring	Shannon	Dent		x	x		x	A	x		
Cypress Cr.	C	3.2	Mouth	24,23N,3E	Ripley			x	x			B	x		
Cypress Cr.	C	15.8	Mouth	18,62N,27W	Daviess	Harrison		x	x			B			
Cypress Ditch #1	C	9.7	State Line	1,22N,4E	Ripley			x	x			B			
Cypress Ditch Lat.	P	8.0	Mouth	20,25N,9E	Stoddard			x	x			B			
Cypress Ditch Lat.	C	6.5	20,25N,9E	29,26N,9E	Stoddard			x	x			B			
Dan R.	C	2.5	32,23N,7E	20,23N,7E	Butler			x	x			B			
Dardenne Cr.	PI	7.0	Mouth	Sur 1704,47N,4E	St. Charles			x	x			B	x		
Dardenne Cr.	P	[16.5]/18.0	[Sur 1704,47N,4E]	[22,46N,2E]	St. Charles			x	x			B	x		
			LG 1704,47N,4E	LG 296,46N,2E											
Dardenne Cr.	C	[8.5]/16.3	[22,46N,2E]	[22,46N,1E]	St. Charles			x	x			B	x		
			LG 296,46N,2E	22,46N,1W		Warren									

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Dark Cr.	C	9.1	Mouth	34,55N,15W	Randolph			x	x			B			
Darrow Br.	C	1.0	Mouth	1,44N,9W	Osage			x	x			B			
Davis Br.	C	4.0	Mouth	2,28N,18W	Webster			x	x			[B]	x		
Davis Cr.	C	8.8	Mouth	30,51N,9W	Andrain			x	x			B	x		
Davis Cr.	C	2.9	Mouth	6,34N,22W	Polk			x	x			B			
Davis Cr.	P	1.2	Mouth	12,29N,20W	Greene			x	x			B			
Davis Cr.	C	3.0	12,29N,20W	2,29N,20W	Greene			x	x			B			
Davis Cr.	C	4.2	Mouth	13,23N,10W	Howell			x	x			B			
Davis Cr.	P	3.5	Mouth	21,62N,38W	Holt			x	x			B			
Davis Cr.	P	25.8	Mouth	8,48N,26W	Saline	Lafayette		x	x			B			
Davis Cr.	C	12.2	8,48N,26W	7,48N,27W	Lafayette			x	x			B	x		
Davis Cr. Ditch	C	6.7	Mouth	6,61N,38W	Holt			x	x			B			
Davisville Hollow	C	2.2	Mouth	31,36N,2W	Crawford			x	x			B			
Day Hollow	C	1.0	Mouth	36,39N,1W	Washington			x	x			B			
Dead Oak Br.	C	1.0	Mouth	2,55N,26W	Caldwell			x	x			B			
Denne Cr.	P	1.3	Mouth	17,38N,14W	Miller			x	x			A	x		
Denne Cr.	C	2.0	20,38N,14W	29,38N,14W	Camden			x	x			B			
Deberry Cr.	C	0.9	Mouth	26,37N,14W	Camden			x	x			B			
Decker Br.	C	2.1	Mouth	35,36N,22W	Hickory			x	x			B			
Deepwater Cr.	C	9.8	Mouth	Montrose Lk Dam	Henry			x	x			B			
Deepwater Cr.	C	5.6	[35,41N,28W] Mouth	5,40N,28W	Henry	Bates		x	x			B			
Deer Cr.	P	11.7	Mouth	21,39N,20W	Benton			x	x	x		B			
Deer Cr.	C	3.3	21,39N,20W	03,38N,20W	Benton			x	x			B			
Deer Cr.	C	1.3	Mouth	12,41N,26W	Henry			x	x			B			
Deer Cr.	P	5.6	Mouth	4,32N,21W	Polk			x	x			B			
Deer Cr.	P	0.8	Mouth	20,45N,8W	Osage			x	x			B			
Deer Cr.	C	4.4	20,45N,8W	34,45N,8W	Osage			x	x			B			
Deer Cr.	P	[1.6]/2.8	Mouth	[1930,45N,6E] 28,45N,6E	St. Louis City	St. Louis		x	x			[B]	x		
Dent Br.	C	1.0	Mouth	[Sur 2374,36N,2E] L.G 2374,36N,2E	Washington			x	x			B			
Des Moines R.	P	[31.3]/29.9	Mouth	State Line	Clark			x	x			A	x		
Devils Den Hollow	C	1.2	Mouth	11,33N,4E	Iron			x	x			B			
Dew Pond Hollow	C	2.7	Mouth	15,30N,07W	Texas			x	x			B			
Dickerson Cr.	C	1.3	Mouth	Binder Lake Dam	Cole			x	x			B			
Dicks Cr.	C	7.3	Mouth	33,54N,33W	Platte			x	x			B	x		
Dicks Fk.	C	5.0	Mouth	28,32N,31W	Barton			x	x			B			
Dicky Cr.	C	1.1	Mouth	14,26N,15W	Douglas			x	x			B			
Dillard Cr.	P	1.5	Mouth	22,31N,11E	Cape Girardeau			x	x			B			
Dillard Cr.	C	1.0	22,31N,11E	16,31N,11E	Cape Girardeau			x	x			B			
Dillon Cr.	C	4.8	Mouth	33,59N,35W	Andrew			x	x			B	x		
Dirt House Hollow	C	1.9	Mouth	[28,29N,07W] 28,29N,7W	Texas			x	x			B			
Ditch #1	C	2.0	19,28N,9E	16,28N,9E	Bollinger			x	x			B			
Ditch #1	C	9.0	Mouth	20,23N,9E	Dunklin			x	x			B			
Ditch #1	P	7.6	13,27N,8E	19,28N,9E	Stoddard	Bollinger		x	x			B			
Ditch #1	P	2.8	30,16N,10E	17,16N,10E	Dunklin			x	x			B			

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Ditch #1	P	17.6	3,24N,13E	[15,27N,13E] 16,27N,13E	New Madrid	Scott		x	x				B		
Ditch #1	C	3.3	16,27N,13E	4,27N,13E	Scott			x	x				B		
Ditch #1	P	86.0	State Line	27,29N,12E	Dunklin	Scott	x	x	x				B	x	
Ditch #1	C	4.3	27,29N,12E	12,29N,12E	Scott		x	x	x				B	x	
Ditch #1	P	7.3	Mouth	16,21N,9E	Dunklin			x	x				B		
Ditch #1	C	3.3	16,21N,9E	6,21N,9E	Dunklin			x	x				B		
Ditch #10	P	3.5	32,27N,8E	17,27N,8E	Stoddard	Wayne		x	x				B		
Ditch #10	C	2.5	17,27N,8E	4,27N,8E	Wayne			x	x				B		
Ditch #10	C	2.7	20,23N,15E	5,23N,15E	New Madrid			x	x				B		
Ditch #101	C	3.5	34,28N,9E	19,28N,10E	Bollinger			x	x				B		
Ditch #104	C	12.5	Mouth	13,25N,13E	New Madrid			x	x				B		
Ditch #11	P	6.0	32,27N,8E	13,27N,8E	Stoddard			x	x				B		
Ditch #11	C	[3.0]7.7	7,24N,8E	1,25N,7E	Butler			x	x				B		
Ditch #110	C	3.1	5,28N,11E	20,29N,11E	Stoddard	Cape Girardeau		x	x				B		
Ditch #16	C	11.2	33,24N,8E	7,25N,8E	Butler			x	x						
Ditch #17	C	7.5	Mouth	31,28N,11E	Stoddard			x	x				B		
Ditch #2	P	3.2	State Line	30,22N,4E	Ripley			x	x				B		
Ditch #2	C	6.0	30,22N,4E	2,22N,4E	Ripley			x	x				B		
Ditch #2	P	4.9	Mouth	35,28N,8E	Stoddard	Wayne		x	x				B		
Ditch #2	C	4.9	23,17N,12E	36,18N,12E	Pemiscot			x	x				B		
Ditch #2	P	17.0	11,20N,10E	24,23N,10E	New Madrid			x	x				B		
Ditch #22	C	7.0	Mouth	2,23N,8E	Butler			x	x				B		
Ditch #23	C	5.8	Mouth	34,24N,8E	Butler			x	x				B		
Ditch #24	P	12.0	23,26N,12E	6,27N,12E	Stoddard			x	x				B		
Ditch #24	C	3.9	6,27N,12E	22,28N,11E	Stoddard			x	x				B		
Ditch #25	P	1.0	15,28N,11E	9,28N,11E	Stoddard			x	x				B		
Ditch #25	C	2.5	9,28N,11E	5,28N,11E	Stoddard			x	x				B		
Ditch #251	P	44.0	State Line	26,22N,12E	Dunklin	New Madrid		x	x				B	x	
Ditch #258	P	10.0	27,19N,10E	9,20N,11E	Dunklin	Pemiscot		x	x				B	x	
Ditch #258	C	5.0	9,20N,11E	25,21N,11E	New Madrid			x	x				B		
Ditch #259	P	26.3	State Line	31,20N,11E	Dunklin	Pemiscot		x	x				B	x	
Ditch #26	P	3.0	Mouth	33,29N,11E	Stoddard	Cape Girardeau		x	x				B		
Ditch #26	C	1.3	33,29N,11E	28,29N,11E	Cape Girardeau								B		
Ditch #27	P	4.5	15,28N,11E	22,29N,11E	Stoddard	Cape Girardeau		x	x				B		
Ditch #287	P	4.8	6,27N,11E	15,28N,11E	Stoddard			x	x				B		
Ditch #290	P	9.2	19,20N,11E	12,21N,11E	Dunklin	New Madrid		x	x				B		
Ditch #290	C	5.3	12,21N,11E	21,22N,12E	New Madrid			x	x				B		
Ditch #293	P	2.9	19,20N,11E	12,20N,10E	Pemiscot			x	x				B		
Ditch #3	P	2.0	[4,18N,9E] Mouth	28,19N,9E	Dunklin			x	x				B		
Ditch #3	C	0.5	28,19N,9E	27,19N,9E	Dunklin			x	x				B		
Ditch #3	C	2.4	Mouth	11,27N,8E	Stoddard			x	x				B		
Ditch #3	P	8.1	6,16N,12E	4,17N,12E	Pemiscot			x	x				B		
Ditch #3	P	18.3	12,20N,10E	6,23N,11E	New Madrid	Stoddard		x	x				B		
Ditch #30	P	4.5	Mouth	1,27N,11E	Stoddard			x	x				B		

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Ditch #33	P	11.8	Mouth	14,28N,11E	Stoddard			x	x			B			
Ditch #33	C	2.0	14,28N,11E	2,28N,11E	Stoddard			x	x			B			
Ditch #34	C	4.5	Mouth	25,29N,11E	Stoddard	Cape Girardeau		x	x			B			
Ditch #34	C	9.0	Mouth	24,28N,12E	Stoddard			x	x			B			
Ditch #35	C	9.2	Mouth	3,27N,12E	Stoddard			x	x			B			
Ditch #36	P	7.8	Mouth	21,19N,10E	Dunklin			x	x			B			
Ditch #4	C	1.5	22,27N,8E	11,27N,8E	Stoddard			x	x			B			
Ditch #4	C	3.5	4,17N,12E	20,18N,12E	Pemiscot			x	x			B			
Ditch #4	P	8.9	34,26N,13E	22,27N,13E	New Madrid	Scott		x	x			B			
Ditch #4	C	4.0	22,27N,13E	33,28N,13E	Scott			x	x			B			
Ditch #4	C	14.0	Mouth	6,22N,11E	Pemiscot	New Madrid		x	x			B			
Ditch #41	C	5.0	Mouth	28,23N,12E	New Madrid			x	x			B			
Ditch #42	C	18.2	Mouth	29,25N,12E	New Madrid	Stoddard		x	x			B			
Ditch #5	C	1.0	28,27N,8E	21,27N,8E	Stoddard			x	x			B			
Ditch #5	P	2.0	12,16N,11E	6,16N,12E	Pemiscot			x	x			B			
Ditch #6	P	1.0	29,27N,8E	21,27N,8E	Stoddard			x	x			B			
Ditch #6	P	16.0	Mouth	15,18N,12E	Pemiscot			x	x			B			
Ditch #6	C	4.5	15,18N,12E	2,18N,12E	Pemiscot			x	x			B			
Ditch #6	P	7.8	Mouth	16,22N,11E	New Madrid			x	x			B			
Ditch #6	C	23.3	16,22N,11E	26,26N,11E	New Madrid	Stoddard		x	x			[B]	x		
Ditch #66	C	2.0	Mouth	33,20N,11E	Pemiscot			x	x			B			
Ditch #66	P	25.0	State Line	1,19N,10E	Pemiscot			x	x			B			
Ditch #7	P	3.0	Mouth	22,16N,11E	Pemiscot			x	x			B			
Ditch #7	C	6.7	Mouth	15,22N,11E	New Madrid			x	x			B			
Ditch #79	P	11.0	4,16N,9E	28,18N,10E	Dunklin			x	x			B			
Ditch #8	C	19.1	12,21N,11E	1,24N,11E	New Madrid	Stoddard		x	x			B	x		
Ditch #80	P	0.5	4,16N,9E	4,16N,9E	Dunklin			x	x			B			
Ditch #81	P	24.0	State Line	11,19N,10E	Dunklin	Pemiscot		x	x			B			
Ditch #84	P	6.0	11,19N,10E	11,20N,10E	Pemiscot			x	x			B			
Ditch #9	P	5.6	17,20N,11E	22,21N,11E	Pemiscot	New Madrid		x	x			B			
Ditch #9	C	3.0	22,21N,11E	12,21N,11E	New Madrid			x	x			B			
Ditch 101	P	1.7	Mouth	34,28N,9E	Stoddard	Bollinger		x	x			B			
Ditch Cr.	P	11.8/3.8	Mouth	12,40N,02E/	Jefferson			x	x			A			
LG 3022,40N,2E															
Ditch to Black R.	P	9.5	Mouth	3,23N,7E	Butler			x	x	x		B			
Ditch to Black R.	C	10.7	3,23N,7E	9,25N,7E	Butler			x	x	x		B	x		
Ditch to Ditch #1	C	1.2	Mouth	28,23N,9E	Dunklin			x	x			B			
Ditch to Ditch #1	C	4.9	Mouth	34,30N,12E	Scott	Cape Girardeau		x	x			B			
Ditch to Ditch #1	P	7.0	Mouth	33,30N,12E	Scott	Cape Girardeau		x	x			B			
Ditch to Ditch #1	P	3.7	Mouth	16,29N,12E	Scott	Cape Girardeau		x	x			B			
Ditch to Ditch #101	C	1.6	Mouth	13,28N,9E	Bollinger			x	x			B			
Ditch to Ditch #2	P	1.5	Mouth	24,22N,3E	Ripley			x	x			B			
Ditch to Ditch #3	P	2.0	Mouth	30,17N,12E	Pemiscot			x	x			B			
Ditch to Ditch #5	C	2.0	Mouth	24,16N,11E	Pemiscot			x	x			B			
Ditch to Ditch #6	C	2.0	Mouth	29,18N,12E	Pemiscot			x	x			B			

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Ditter Cr.	C	1.2	Mouth	03,41N,23W	Benton			x	x			B			
Doe Cr.	C	6.1	Mouth	4,50N,15W	Howard			x	x			B			
Doe Run Cr.	P	6.1	Mouth	27,35N,5E	St. Francois			x	x			B			
Doe Run Cr.	C	3.5	27,35N,5E	20,35N,5E	St. Francois			x	x			B	x		
Dog Cr.	P	2.9	Mouth	12,40N,14W	Miller			x	x			B			
Dog Cr.	C	7.0	12,40N,14W	4,39N,14W	Miller			x	x			B	x		
Dog Cr.	C	5.7	Mouth	9,58N,28W	Daviess			x	x			B	x		
Dog Hollow	C	2.0	Mouth	30,33N,14E	Cape Girardeau			x	x			B			
Doolan Chute	P	9.6	Mouth	30,29N,15E	Scott			x	x			B	x		
Dooling Cr.	P	1.5	Mouth	11,45N,8W	Osage			x	x			B			
Dooling Cr.	C	1.0	11,45N,8W	11,45N,8W	Osage			x	x			B			
Doolittle Cr.	C	2.3	Mouth	03,29N,12W	Texas			x	x			[B]	x		
Doss Br.	P	2.2	Mouth	17,38N,2W	Crawford			x	x			B			
Doss Br.	C	2.0	17,38N,2W	15,38N,2W	Crawford			x	x			B			
Double Br.	C	5.8	Mouth	19,39N,30W	Bates			x	x			B	x		
Douger Br.	C	[3.1]/2.8	Mouth	11,26N,26W	Lawrence			x	x			B	x		
Douglas Br.	C	4.3	Mouth	13,36N,32W	Vernon			x	x			B			
Dousinbury Cr.	P	3.9	Mouth	17,33N,18W	Dallas			x	x			B			
Dousinbury Cr.	C	2.0	17,33N,18W	15,33N,18W	Dallas			x	x			B			
Dove Cr.	C	[2.0]/10.3	Mouth	12,29N,13W	Wright			x	x			B			
Doxies Cr.	C	12.4	Mouth	5,51N,16W	Chariton	Howard		x	x			B			
Drunken Cr.	P	1.0	Mouth	Sur1200,30N,10E	Bollinger			x	x			B			
Drunken Cr.	C	1.5	Sur1200,30N,10E	34,31N,10E	Bollinger			x	x			B			
Dry Auglaize Cr.	P	5.2	24,38N,15W	22,38N,15W	Camden			x	x			A	x		
Dry Auglaize Cr.	C	34.5	22,38N,15W	8,35N,15W	Camden	Laclede		x	x			A	x		
Dry Auglaize Cr.	P	7.6	8,35N,15W	2,34N,16W	Laclede			x	x			B			
Dry Bone Cr.	C	1.8	Mouth	20,30N,7W	Texas			x	x			B			
Dry Br.	P	3.6	Mouth	6,28N,23W	Greene			x	x			B			
Dry Br.	C	1.7	6,28N,23W	7,28N,23W	Greene			x	x			B			
Dry Br.	C	2.6	Mouth	Sur 1710,51N,1W	Lincoln			x	x			B			
Dry Br.	C	5.1	Mouth	3,49N,2W	Lincoln			x	x			B			
Dry Br.	C	5.3	Mouth	4,39N,1E	Washington			x	x			B			
Dry Br.	C	0.5	Mouth	8,49N,1E	Lincoln			x	x			B			
Dry Cr.	P	1.3	Mouth	27,39N,9W	Maries			x	x			B			
Dry Cr.	C	1.5	27,39N,9W	29,39N,9W	Maries			x	x			B			
Dry Cr.	P	5.0	Mouth	14,37N,3W	Crawford			x	x		x	A			
Dry Cr.	C	8.3	14,37N,3W	16,36N,3W	Crawford			x	x			B			
Dry Cr.	C	3.5	Mouth	24,36N,3E	Washington			x	x			[B]	x		
Dry Cr.	C	1.0	Mouth	27,36N,4E	St. Francois			x	x			B			
Dry Cr.	C	5.0	Mouth	12,24N,25W	Stone	Barry		x	x			B			
Dry Cr.	C	15.0	Mouth	8,25N,9W	Douglas	Howell		x	x			B			
Dry Cr.	C	1.5	Mouth	1,24N,13W	Ozark			x	x			B			
Dry Cr.	P	1.0	Mouth	9,28N,3E	Wayne			x	x			B			
Dry Cr.	C	2.7	9,28N,3E	32,29N,3E	Wayne			x	x			B			
Dry Cr.	C	4.5	Mouth	27,32N,6E	Madison			x	x			B			
Dry Cr.	P	9.3	Mouth	25,40N,03E	Jefferson			x	x			B			
Dry Cr.	C	2.8	Mouth	11,48N,21W	Saline			x	x			[B]	x		

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Dry Cr.	P	8.8	Mouth	32,30N,10E	Bollinger			x	x			B			
Dry Cr.	C	4.5	32,30N,10E	24,30N,9E	Bollinger			x	x			B			
Dry Cr.	C	2.2	Mouth	1,40N,4E	Jefferson			x	x			B			
Dry Fk.	P	7.7	Mouth	8,34N,23W	Polk			x	x			B			
Dry Fk.	C	1.0	8,34N,23W	8,34N,23W	Polk			x	x			B			
Dry Fk.	P	4.0	Mouth	35,47N,6W	Montgomery			x	x			B			
Dry Fk.	C	3.3	35,47N,6W	10,46N,6W	Montgomery			x	x			B			
Dry Fk.	C	2.3	Mouth	22,35N,9E	Perry			x	x			B			
Dry Fk.	C	3.2	Mouth	18,35N,12E	Perry			x	x			B			
Dry Fk.	P	23.3	Mouth	22,37N,7W	Phelps		x	x	x			B			
Dry Fk.	C	27.0	22,37N,7W	20,35N,6W	Phelps	Dent		x	x			B			
Dry Fk.	P	12.7	Mouth	35,41N,6W	Gasconade			x	x			B			
Dry Fk.	C	3.4	Mouth	29,29N,27W	Lawrence			x	x			B			
Dry Fk.	C	10.2	Mouth	8,29N,30W	Jasper			x	x			A			
Dry Fk.	C	2.4	Mouth	11,46N,11W	Callaway			x	x			B			
Dry Fk.	C	2.0	Mouth	20,50N,17W	Howard			x	x			B			
Dry Fk.	C	3.6	Mouth	28,45N,16W	Moniteau			x	x			[B]	x		
Dry Fk. Cr.	P	4.0	20,35N,6W	29,35N,6W	Dent			x	x			B			
Dry Fk. Cr.	C	11.1	29,35N,6W	25,34N,7W	Dent			x	x			B	x		
[Dry Fk. Cr.]	C	[13.3/24.0]	35,41N,6W	[6,40N,7W]	Gasconade	Maries		x	x			B	x		
Dry Fk.				2,39N,8W											
Dry Hollow	C	5.1	Mouth	31,22N,27W	Barry			x	x			B			
Dry Hollow	C	2.5	Mouth	34,24N,16W	Ozark			x	x			B			
Dry Hollow	C	0.5	Mouth	22,28N,28W	Lawrence			x	x						
Dry Valley Br.	P	1.6	Mouth	26,27N,29W	Newton			x	x			B			
Dry Valley Br.	C	1.3	26,27N,29W	25,27N,29W	Newton	Lawrence		x	x				x		
Dry Valley Cr.	C	2.3	Mouth	1,34N,5W	Dent			x	x			B			
Dry Wood Cr.	P	29.9	Mouth	4,32N,33W	Vernon	Barlon		x	x			B			
Dubois Cr.	P	3.0	Mouth	Sur 404,44N,1E	Franklin			x	x			B			
Dubois Cr.	C	4.8	Sur 404,44N,1E	11,43N,1W	Franklin			x	x			B			
Duck Cr.	C	3.4	Mouth	32,43N,23W	Henry	Benton		x	x			B			
Duck Cr.	C	5.3	Mouth	21,27N,9E	Stoddard			x	x			B	x		
Duck Cr.	C	6.9	Mouth	16,58N,14W	Macon			x	x			B			
Dudley Main Ditch	P	6.4	Mouth	34,25N,9E	Stoddard			x	x			B			
Dudley Main Ditch	C	0.8	34,25N,9E	27,25N,9E	Stoddard			x	x						
Dulin Cr.	P	1.4	Mouth	09,42N,04E	Jefferson			x	x			B			
Duncan Cr.	C	2.6	Mouth	8,37N,33W	Vernon			x	x			B			
Duncan Cr.	C	3.2	Mouth	22,38N,10W	Phelps			x	x			B			
Dunlap Cr.	C	0.5	Mouth	13,47N,9W	Callaway			x	x			B			
Dunn Spring Cr.	C	2.3	Mouth	34,44N,1E	Franklin			x	x			B	x		
Duran Cr.	C	8.1	Mouth	02,41N,22W	Benton			x	x			B			
Durington Cr.	C	4.6	Mouth	06,34N,19W	Dallas			x	x			B			
Duskin Cr.	C	2.0	Mouth	13,32N,13E	Cape Girardeau			x	x			B			
Dutch Cr.	P	1.6	Mouth	27,42N,03E	Jefferson			x	x			B			
Dutchtown Ditch	P	10.0	Mouth	25,30N,12E	Cape Girardeau			x	x			B			
Dutro Carter Cr.	P	1.5	Mouth	18,37N,7W	Phelps			x	x			B			
Dutro Carter Cr.	C	0.5	18,37N,7W	18,37N,7W	Phelps			x	x			B			
Duval Cr.	C	7.0	Mouth	13,30N,32W	Jasper			x	x			B			

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Dyer Rock Cr.	C	5.1	Mouth	03,49N,24W	Lafayette			x	x			B			
E. Bear Cr.	C	1.2	Mouth	33,46N,25W	Johnson			x	x			B	x		
E. Br. Crawford Cr.	C	4.0	32,46N,29W	20,46N,29W	Cass			x	x			B			
E. Br. Elkhorn Cr.	C	4.7	Mouth	19,63N,36W	Nodaway			x	x			B			
E. Br. S. Grand R.	C	[14.0]/17.0	Mouth	[11,44N,32W] 36,45N,32W	Cass			x	x			B	x		
E. Br. Squaw Cr.	C	4.2	Mouth	5,62N,38W	Holt			x	x			B			
E. Brush Cr.	C	9.0	Mouth	16,45N,15W	Moniteau			x	x			B			
E. Chan. Whitewater R.	C	4.8	Mouth	16,28N,12E	Scott			x	x			B			
E. Cow Cr.	C	2.2	Mouth	19,51N,20W	Saline			x	x			B			
E. Ditch #1	P	22.0	Mouth	11,22N,10E	Dunklin	New Madrid		x	x			B	x		
E. Ditch #1	C	3.0	11,22N,10E	27,23N,10E	New Madrid			x	x			B	x		
E. Fk. Big Cr.	P	18.4	9,63N,28W	5,64N,27W	Harrison			x	x			B		x	
E. Fk. Big Cr.	C	21.1	5,64N,27W	State Line	Harrison			x	x			B	x	x	
E. Fk. Big Cr.	C	3.2	21,31N,7E	9,31N,7E	Madison			x	x			B			
E. Fk. Big Cr.	P	1.4	29,31N,7E	21,31N,7E	Madison			x	x			A			
E. Fk. Big Muddy Cr.	C	2.0	3,65N,29W	35,66N,29W	Harrison			x	x			B			
E. Fk. Black R.	P	17.1	Mouth	29,34N,3E	Reynolds	Iron		x	x			A		x	
E. Fk. Black R.	C	0.7	29,34N,3E	21,34N,3E	Iron			x	x			B			
E. Fk. Bull Cr.	C	2.4	Mouth	23,26N,20W	Christian			x	x			B			
[E. Fk. Chariton R.] E. Fk. Little Chariton R.	C	17.8	Mouth	11,60N,15W	Macon			x	x			B		x	
E. Fk. Crooked R.	P	19.9	Mouth	29,54N,27W	Ray			x	x			B			
E. Fk. Crooked R.	C	6.4	29,54N,27W	5,54N,27W	Ray			x	x			B			
E. Fk. Drywood Cr.	C	13.5	Mouth	8,32N,32W	Barton			x	x			B			
E. Fk. E. Br. S. Grand R.	C	3.9	Mouth	31,45N,31W	Cass			x	x			B			
E. Fk. Fishing R.	C	12.9	Mouth	20,53N,29W	Clay	Ray		x	x			B	x		
E. Fk. Fourche Cr.	P	3.0	Mouth	3,22N,1E	Ripley			x	x			B			
E. Fk. Fourche Cr.	C	2.4	3,22N,1E	35,23N,1E	Ripley			x	x			B			
E. Fk. Grand R.	P	28.7	Mouth	29,66N,30W	Gentry	Worth	x	x	x			A	x	x	
E. Fk. Grand R.	C	6.5	29,66N,30W	10,66N,30W	Worth			x	x			B			
E. Fk. Huzzah Cr.	P	5.5	1,34N,3W	20,34N,2W	Dent			x	x			B			
E. Fk. Huzzah Cr.	C	2.0	20,34N,2W	29,34N,2W	Dent			x	x			B			
E. Fk. L. Blue R.	P	1.0	Mouth	27,49N,31W	Jackson			x	x			B			
E. Fk. L. Blue R.	C	3.7	27,49N,31W	Blue Springs Lake	Jackson			x	x			B			
E. Fk. L. Gravois Cr.	C	3.3	Mouth	3,40N,15W	Miller			x	x			B	x		
E. Fk. L. Tarkio Cr.	C	17.8	Mouth	21,65N,38W	Holt	Atchison	x	x	x			B			
E. Fk. Little Chariton R.	P	74.0	Mouth	7,57N,14W	Chariton	Macon	x	x	x			B		x	
[E. Fk. Locust Cr.]	P	16.7	Mouth	2,62N,20W	Sullivan			x	x			B			
E. Locust Cr. [E. Fk. Locust Cr.]	C	15.7	2,62N,20W	12,64N,20W	Sullivan			x	x			[B]	x		
E. Locust Cr.															
E. Fk. Lost Cr.	P	8.0	Mouth	17,28N,7E	Wayne			x	x			B			
E. Fk. Lost Cr.	C	10.0	Mouth	11,60N,31W	DeKalb			x	x			B			
E. Fk. Niangua R.	C	6.3	33,32N,18W	25,31N,18W	Webster			x	x			A			
E. Fk. Postcreek Cr.	C	12.2	Mouth	9,44N,26W	Johnson			x	x			B	x		
E. Fk. Rock Cr.	C	4.0	Mouth	31,23N,25W	Barry			x	x			B			

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E. Fk. Roubidoux Cr.	C	4.9	Mouth	24,31N,11W	Texas			x	x			B			
E. Fk. Salt Pond Cr.	C	1.6	Mouth	19,49N,22W	Saline			x	x			B			
E. Fk. Shoal Cr.	C	2.9	Mouth	4,51N,32W	Clay			x	x			B			
E. Fk. Sni-a-bar Cr.	C	8.9	32,49N,28W	29,48N,28W	Lafayette			x	x			B			
E. Fk. Sni-a-bar Cr.	P	9.6	Mouth	32,49N,28W	Lafayette			x	x			B			
E. Fk. Sulphur Cr.	C	2.5	Mouth	30,50N,17W	Howard			x	x			B			
E. Fk. Tebo Cr.	C	14.5	31,43N,24W	35,44N,24W	Henry			x	x			B	x		
E. Fk. Walnut Cr.	C	1.8	Mouth	28,55N,14W	Randolph			x	x			B			
E. Honey Cr.	C	13.6	[29,63N,23W] Mouth	2,64N,23W	Grundy	Mercer		x	x				x		
E. Prong Crooked Cr.	C	3.8	Mouth	17,35N,3W	Dent	Crawford		x	x			B			
E. Yellow Cr.	P	35.0	20,56N,19W	7,60N,18W	Chariton	Linn		x	x			B	x		
E.Fk. Bee Br.	C	0.9	Mouth	16,37N,30W	Vernon			x	x			B			
Earle Br.	C	0.7	Mouth	Hwy. F	Phelps			x	x			B			
East Cr.	C	9.4	2,44N,33W	31,46N,32W	Cass			x	x			B	x		
East Prong	C	1.0	Mouth	12,31N,7E	Madison			x	x			B			
East Prong Indian Cr.	C	2.5	6,25N,7E	30,26N,7E	Butler			x	x			B			
East Whetstone Cr.	C	[5.5/8.8	21,29N,13W	[6,28N,12W] 9,28N,12W	Wright			x	x			B	x		
Eaton Br.	C	[1.2/3.0	Mouth	[4,36N,4E] 9,36N,4E	St. Francois			x	x			[B]	x		
Ebo Cr.	P	1.6	Mouth	13,38N,1E	Washington			x	x			B			
Ebo Cr.	C	1.1	13,38N,1E	14,38N,1E	Washington			x	x			B			
Eddington Br.	P	2.0	Mouth	1,29N,26W	Lawrence			x	x			B			
Eddington Br.	P	1.4	Mouth	5,29N,25W	Lawrence			x	x			B			
Edmondson Cr.	C	1.9	Mouth	4,52N,20W	Saline			x	x			B			
Eight Mile Cr.	C	16.8	Mouth	36,44N,31W	Cass			x	x			B			
Elbow Cr.	P	2.6	Mouth	27,22N,18W	Taney			x	x			B			
Eleven Point R.	P	22.7	State Line	18,24N,2W	Oregon		x	x	x	x		A	x		
Eleven Point R.	P	11.4	18,24N,2W	36,25N,4W	Oregon			x	x		x	A	x		
Eleven Point R.	P	[22.3/22.0	36,25N,4W	23,25N,6W	Oregon			x	x	x		A	x		
Eleven Point R.	C	36.3	23,25N,6W	32,27N,9W	Oregon	Howell		x	x	x		B			
Elk Br.	C	2.8	Mouth	08,45N,22W	Pettis			x	x			B			
Elk Chute Ditch	P	13.1	Mouth	27,18N,10E	Dunklin			x	x			B			
Elk Cr.	P	5.0	Mouth	33,32N,14W	Wright			x	x			B			
Elk Cr.	C	1.5	33,32N,14W	5,31N,14W	Wright			x	x			B			
Elk Cr.	P	2.4	Mouth	24,29N,10W	Texas			x	x			B			
Elk Cr.	C	2.3	24,29N,10W	30,29N,9W	Texas			x	x			B			
Elk Cr.	C	1.5	Mouth	29,47N,23W	Pettis			x	x			B			
Elk Cr.	C	5.7	[14,61N,19W] 14,55N,21W	6,55N,20W	Chariton			x	x			B			
Elk Cr.	C	11.5	Silver Lake	25,57N,20W	Chariton	Linn		x	x			B	x		
Elk Fk.	C	[10.5/10.8	Mouth	[35,42N,30W] 34,42N,30W	Bates			x	x			B			
Elk Fk.	P	7.0	Mouth	04,44N,23W	Pettis			x	x			B			
Elk Fk. Salt R.	P	7.7	Mouth	26,54N,10W	Monroe			x	x			B	x		
Elk Fk. Salt R.	C	38.6	26,54N,10W	16,54N,13W	Monroe	Randolph		x	x			B	x		
Elk R.	P	23.2	State Line	34,22N,32W	McDonald		x	x	x	x		A	x		

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Elkhorn Br.	C	1.5	Mouth	6,21N,8W	Howell			x	x			B			
Elkhorn Cr.	C	21.4	Mouth	3,48N,5W	Montgomery			x	x			B	x		
Elkhorn Cr.	C	2.3	Mouth	3,26N,19W	Christian			x	x			B			
Elkhorn Cr.	C	11.8	Mouth	13,63N,37W	Nodaway			x	x			B	x		
Elkhorn Cr.	P	5.8	Mouth	26,23N,31W	McDonald		x	x	x			B			
Elm Br.	C	3.0	Mouth	7,43N,23W	Henry			x	x			B	x		
Elm Br.	C	3.0	Mouth	27,53N,8W	Monroe			x	x			B			
[Elm Br.]	C	4.5	Mouth	3,65N,21W	Putnam			x	x			B			
Elm Br.															
Elm Cr.	C	9.6	Mouth	20,66N,15W	Schuyler			x	x			B			
Elm Grove Br.	C	4.2	Mouth	27,61N,33W	DeKalb	Gentry		x	x			B			
Elm Spring Br.	C	[1.0]/2.2	[6,24N,31W]	7,24N,31W	Newton			x	x			[B]	x		
			34,25N,31W												
Elm Spring Br.	P	0.8	Mouth	34,25N,31W	Newton			x	x			B			
Ely Cr.	C	[4.3]/6.4	Mouth	[1,55N,7W]	Ralls			x	x			B			
				34,56N,7W											
Emery Hollow	C	3.9	Mouth	28,31N,10W	Texas			x	x				x		
Emory Cr.	C	2.0	Mouth	31,24N,21W	Taney			x	x			[B]	x		
English Cr.	C	2.8	State Line	33,22N,6W	Oregon			x	x			B			
Establishment Cr.	P	[17.7]/17.0	Mouth	[23,37N,7E]	Ste. Genevieve			x	x			B			
				LG 884,37N,7E											
Establishment Cr.	C	[2.5]/4.6	[23,37N,7E]	33,37N,7E	Ste. Genevieve			x	x			B			
			LG												
			2060,37N,7E												
Establishment Cr.	P	0.4	LG 2060,37N,7E	LG 2060,37N,7E	Ste. Genevieve			x	x			B			
Fabius Island Chute	P	2.7	Mouth	28,59N,5W	Marion		x	x	x			B	x		
Fabius R.	Pf	3.5	Mouth	24,59N,6W	Marion		x	x	x			B	x		
Factory Cr.	P	1.7	Mouth	2,46N,14W	Moniteau			x	x			B			
Factory Cr.	C	4.2	2,46N,14W	32,47N,14W	Moniteau			x	x			B	x		
Fall Cr.	P	1.0	Mouth	11,22N,22W	Taney			x	x			B			
Fall Cr.	C	3.9	11,22N,22W	28,23N,22W	Taney	Stone		x	x			B			
Fassnight Cr.	P	2.8	Mouth	25,29N,22W	Greene			x	x			B			
Fassnight Cr.	C	1.2	25,29N,22W	30,29N,21W	Greene			x	x			[B]	x		
Feaster Cr.	C	0.6	Mouth	31,41N,21W	Benton			x	x			B			
Fee Fee Cr. (new)	P	1.5	Mouth	Sur 992,46N,5E	St. Louis			x	x			B			
Fee Fee Cr. (old)	P	1.0	Mouth	1 Mi. above Hwy. 70	St. Louis			x	x			B			
Femme Osage Cr.	P	8.2	Mouth	29,45N,2E	St. Charles			x	x			B			
Femme Osage Cr.	C	2.0	29,45N,2E	24,45N,1E	St. Charles			x	x			B			
Fenton Cr.	C	0.6	Mouth	23,43N,1W	Franklin			x	x				x		
Fenton Cr.	P	0.5	Mouth	[35,43N,05E]	St. Louis			x	x			B			
				35,43N,5E											
Fiddle Cr.	C	3.8	Mouth	[16,44N,2E]	Franklin			x	x			B			
				LG 161,44N,2E											
Fidelity Br.	P	2.6	Mouth	9,27N,31W	Jasper			x	x			B			
Fiery Fk.	C	2.0	Mouth	26,39N,19W	Camden			x	x			B			
Finley Cr.	P	51.6	Mouth	19,28N,16W	Stone	Webster		x	x	x		A	x		
Finn Br.	C	3.5	4,35N,8W	1,35N,8W	Phelps	Dent		x	x			B			
Finney Cr.	P	1.2	Mouth	28,49N,21W	Saline			x	x			B	x		

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Finney Cr.	C	2.4	28,49N,21W	20,49N,21W	Saline			x	x			B			
Fire Br.	C	[5.4]/5.8	Mouth	27,54N,28W	Ray			x	x			B			
Fire Prairie Cr.	P	13.0	Mouth	18,50N,30W	Jackson			x	x			B			
First Cr.	P	1.6	Mouth	14,45N,6W	Gasconade			x	x			B			
First Cr.	C	10.7	14,45N,6W	5,44N,5W	Gasconade			x	x			B			
First Cr.	C	4.7	Mouth	9,52N,33W	Clay	Platte		x	x			B			
Fish Br.	C	1.9	Mouth	28,52N,9W	Audrain			x	x			B			
Fish Cr.	C	12.4	Mouth	21,51N,19W	Saline			x	x			B			
[Fish Lake Ditch]	C	6.5	3,24N,16E	28,25N,17E	Mississippi			x	x			B			
<b>Ditch to Tennile Pond</b>															
Fish Lake Ditch	C	2.4	14,26N,16E	1,26N,16E	Mississippi			x	x			B			
Fish Trap Slough	C	8.2	State Line	33,23N,8E	Butler			x	x			B			
Fishing R.	P	26.4	Mouth	3,52N,31W	Ray	Clay	x	x	x			B			
Fishing R.	C	8.5	3,52N,31W	24,52N,32W	Clay			x	x			B	x		
Fishpot Cr.	P	3.5	Mouth	13,44N,04E	St. Louis			x	x			B			
Fishwater Cr.	P	4.8	Mouth	33,35N,4W	Dent			x	x			B			
Fivemile Cr.	P	5.0	State Line	21,26N,33W	Newton		x	x	x			B			
Flagstaff Cr.	C	4.7	Mouth	3,47N,25W	Johnson			x	x			B			
Flat Cr.	C	13.5	Mouth	2,54N,13W	Monroe	Randolph		x	x			B			
Flat Cr.	P	42.3	28,24N,24W	9,23N,27W	Stone	Barry		x	x	x		A	x		
Flat Cr.	P	2.5	9,23N,27W	21,23N,27W	Barry		x	x	x		x	A	x		
Flat Cr.	P	8.3	21,23N,27W	13,22N,28W	Barry			x	x	x		A	x		
Flat Cr.	C	6.0	Mouth	20,24N,3E	Ripley			x	x			B			
Flat Cr.	C	1.2	Mouth	27,43N,1W	Franklin			x	x			B	x		
Flat Cr.	P	2.7	Mouth	[1,43N,03E]	St. Louis			x	x			B			
<b>LG 2071,43N,3E</b>															
Flat Cr.	P	23.7	Mouth	13,45N,21W	Morgan	Pettis		x	x			B	x		
Flat Cr.	C	22.0	13,45N,21W	02,43N,23W	Pettis			x	x			B	x		
Flat Cr.	C	6.4	Mouth	8,49N,19W	Saline	Cooper		x	x			B			
[Flat River Cr.]	C	10.0	Mouth	21,36N,4E	St. Francois			x	x			B	x		
Flat R.															
Flat Rock Cr.	C	0.5	Mouth	05,40N,20W	Benton			x	x			B			
Flatrock Cr.	P	2.0	Mouth	1,33N,12E	Cape Girardeau			x	x			B			
Flatrock Cr.	C	1.5	1,33N,12E	12,33N,12E	Cape Girardeau			x	x			B			
Fleck Cr.	C	4.3	Mouth	29,32N,33W	Barton			x	x			B			
Flethall Cr.	C	4.0	Mouth	State Line	Worth			x	x			B			
Fletcher Br.	P	0.4	Mouth	31,39N,5E	Jefferson			x	x			A			
Flinger Br.	C	1.7	Mouth	[17,28N,08W]	Texas			x	x				x		
Flint Bottom Cr.	C	3.0	Mouth	17,28N,8W											
Flint Hill Br.	P	3.3	Mouth	21,37N,8E	Ste. Genevieve			x	x			B			
Flora Cr.	P	6.0	Mouth	9,30N,22W	Greene			x	x			B			
Florida Cr.	C	8.4	Mouth	35,32N,14E	Cape Girardeau			x	x			B			
Floyd Cr.	C				Nodaway			x	x			[B]	x		
Floyd Cr.	C	[5.1]/17.1	Mouth	[29,63N,14W]	Adair			x	x			B	x		
Flucom Br.	C	1.7	Mouth	32,63N,15W											
Fly Cr.	P	2.5	Mouth	12,39N,5E	Jefferson			x	x			[B]	x		
Fly Cr.	P	2.5	Mouth	30,40N,9W	Maries			x	x			B			
Fly Cr.	C	0.5	30,40N,9W	30,40N,9W	Maries			x	x			B			
Fly Cr.	C	5.6	Mouth	02,35N,29W	Vernon			x	x			B			

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Fonso Br.	P	1.7	Mouth	6,47N,6W	Montgomery			x	x			B			
Fork Cr.	C	4.8	Mouth	6,44N,4W	Franklin	Gasconade		x	x			B			
Fortune Br.	C	2.7	Mouth	9,23N,26W	Barry			x	x			B			
Foster Cr.	C	2.0	Mouth	4,30N,12E	Cape Girardeau			x	x			B			
Fountain Farm Br.	C	1.8	Mouth	32,38N,03E	Washington			x	x				x		
Fourche a DuClos Cr.	P	8.2	Mouth	30,38N,7E	Ste. Genevieve			x	x			B			
Fourche a DuClos Cr.	C	3.0	30,38N,7E	3,37N,6E	Ste. Genevieve			x	x			B			
Fourche a Renault Cr.	P	8.8	7,38N,2E	Sumner Lake Dam	Washington			x	x			B			
Fourche a Renault Cr.	P	0.5	Sumner Lake	15,37N,1E	Washington			x	x			B			
Fourche a Renault Cr.	C	2.4	15,37N,1E	23,37N,1E	Washington			x	x			B			
Fourche Cr.	P	114.6/13.6	State Line	115,23N,1W	Ripley			x	x	x	x	A	x		
Fourche Cr.	P	0.2	15,23N,1W	15,23N,1W	Ripley			x	x	x	x	A	x		
Fourmile Cr.	C	5.5	Mouth	29,34N,18W	Dallas			x	x			B			
Fowler Cr.	C	6.0	Mouth	13,46N,12W	Boone			x	x			B	x		
Fox Cr.	P	7.2	Mouth	30,44N,03E	St. Louis			x	x			B			
Fox Cr.	C	0.5	Mouth	28,22N,20W	Taney			x	x			B			
Fox Cr.	P	4.0	Mouth	9,25N,13W	Douglas			x	x			B			
Fox Cr.	C	5.0	9,25N,13W	29,26N,13W	Douglas			x	x			B			
Fox Cr.	C	6.1	Mouth	20,63N,26W	Harrison			x	x			B			
Fox R.	P	12.3	Mouth	6,64N,6W	Clark			x	x			B	x	x	
Fox R.	P	42.0	6,64N,6W	State Line	Clark			x	x			B	x		
Franklin Cr.	C	3.0	Mouth	32,26N,7E	Butler			x	x			B			
Frederick Cr.	C	15.0	8,22N,2W	2,22N,4W	Oregon			x	x			B	x		
Frederick Cr.	P	3.4	Mouth	8,22N,2W	Oregon			x	x			A	x		
Frene Cr.	P	1.8	Mouth	35,46N,5W	Gasconade			x	x			B			
Frene Cr.	C	3.3	35,46N,5W	10,45N,5W	Gasconade			x	x			B			
Froe Hollow	P	2.0	Mouth	34,34N,4E	Iron			x	x			B			
Froggy Br.	C	1.2	Mouth	5,33N,11E	Cape Girardeau			x	x			B			
Funk Br.	C	3.3	Mouth	32,31N,3E	Reynolds	Iron		x	x			B			
Furnace Cr.	P	2.8	Mouth	14,36N,2E	Washington			x	x			B			
Gabriel Cr.	P	5.0	Mouth	7,44N,18W	Morgan			x	x			A	x		
Gabriel Cr.	C	13.6	107,44N,18W	103,42N,19W	Morgan			x	x			B	x		
Galbreath Cr.	C	5.8	7,44N,18W	3,42N,19W	Monroe	Randolph		x	x			B			
Galena Hollow	C	3.6	Mouth	20,23N,26W	Barry			x	x			B			
Galligher Cr.	P	0.2	Mouth	20,41N,4E	Jefferson			x	x			B			
Gallinipper Cr.	C	1.3	Mouth	36,39N,26W	St. Clair			x	x			B			
Gallinipper Cr.	C	3.0	36,39N,26W	27,39N,26W	St. Clair			x	x			B			
Galloway Cr.	P	3.2	Mouth	4,28N,21W	Greene			x	x			B			
Ganaway Cr.	C	2.0	Mouth	25,52N,16W	Howard			x	x			B			
Gans Cr.	C	5.5	1,47N,13W	133,48N,12W	Boone			x	x			A			
Garrison Br.	C	2.0	Mouth	29,25N,19W	Christian			x	x			B			
Garrison Br.	C	0.7	23,27N,21W	23,27N,21W	Christian			x	x			B			

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Garrison Fk.	C	6.8	Mouth	13,50N,27W	Lafayette			x	x			B			
Gasconade R.	P	264.0	Mouth	[6,29N,14W]	Gasconade	Wright		x	x	x		A	x	x	
[Gasconade R.]	P	11.2	[6,29N,14W]	5,29N,14W	Wright			x	x			B			
Lick Fk. Gasconade R.			5,29N,14W												
[Gasconade R.]	C	4.8	26,29N,16W	19,29N,16W	Wright	Webster		x	x			B			
Lick Fk. Gasconade R.															
Gees Cr.	C	13.8	Mouth	29,60N,25W	Livingston	Grundy		x	x			B			
Gillum Cr.	C	2.5	Mouth	23,39N,33W	Bates			x	x				x		
Gimlet Cr.	P	1.5	Mouth	26,31N,7E	Madison			x	x			B			
Girard Br.	C	2.5	Mouth	33,41N,1E	Franklin			x	x			B			
Givins Br.	C	4.7	Mouth	11,31N,19W	Webster			x	x			B			
Gizzard Cr.	P	0.9	Mouth	27,30N,7E	Wayne			x	x			B			
Gizzard Cr.	P	[2.0/2.9]	Mouth	6,29N,11E	Cape Girardeau	Bollinger		x	x			B			
Gizzard Cr.	C	1.6	6,29N,11E	36,30N,10E	Bollinger			x	x			B			
Gladden Cr.	P	2.5	Mouth	13,31N,6W	Shannon			x	x			B			
Gladden Cr.	C	15.2	13,31N,6W	5,32N,5W	Shannon	Dent		x	x			B			
Glade Cr.	C	0.9	Mouth	Sur 2081,30N,4E	Iron			x	x			B			
Glaize Cr.	P	[6.1/5.9]	Mouth	[22,42N,5E]	Jefferson			x	x			B			
Glaize Cr.	C	2.0	[22,42N,5E]	LG 1311,42N,5E	Jefferson			x	x			[B]	x		
			LG 1311,42N,5E												
Glendale Fk.	C	5.4	Mouth	14,31N,33W	Barton			x	x				x		
Goldsbury Hollow	C	2.7	Mouth	31,23N,16W	Ozark			x	x			B			
Goose Cr.	P	4.0	Mouth	10,28N,25W	Lawrence			x	x		x	B			
Goose Cr.	C	[6.5/3.6]	Mouth	25,38N,6E	Ste. Genevieve	[St. Francois]		x	x			B	x		
Goose Cr.	P	4.0	Mouth	17,35N,10E	Perry			x	x			B			
Goose Cr.	C	1.3	17,35N,10E	24,35N,9E	Perry			x	x			B			
Goose Cr.	P	1.0	Mouth	18,39N,1E	Washington			x	x			B			
Goose Cr.	C	2.0	18,39N,1E	21,39N,1E	Washington			x	x			B			
Goose Cr.	C	2.8	Mouth	Sur 837,35N,2E	Washington			x	x			[B]	x		
Goose Cr.	C	3.0	Mouth	Sur 183,31N,13E	Cape Girardeau			x	x				x		
Goose Cr.	C	1.5	Mouth	30,29N,7E	Wayne			x	x			B			
Goose Cr.	C	4.0	Mouth	28,26N,5E	Butler			x	x			B	x		
Goose Cr.	P	1.4	Mouth	22,33N,7E	Madison			x	x			B			
Goose Cr.	C	1.6	22,33N,7E	27,33N,7E	Madison			x	x			B			
Goose Cr.	P	2.4	Mouth	32,62N,29W	Daviess			x	x			B			
Goose Cr.	C	4.4	Mouth	14,56N,29W	Caldwell			x	x			B			
Goose Pond Ditch	C	4.3	21,27N,9E	8,26N,9E	Stoddard			x	x			B			
Gooseneck Br.	C	2.5	Mouth	22,37N,20W	Hickory			x	x			B			
Gordon Cr.	P	2.0	Mouth	15,32N,3W	Dent			x	x			B			
Gordon Cr.	C	0.5	15,32N,3W	11,32N,3W	Dent			x	x			B			
Gower Br.	C	2.3	Mouth	09,32N,19W	Dallas			x	x			B			
Gracey Cr.	C	2.0	Mouth	6,42N,16W	Morgan			x	x			B			
Grand Glaize Cr.	C	[4.0/2.8]	Mouth	[9,44N,5E]	St. Louis			x	x			B			
				16,44N,5E											

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Grand Glaize Cr.	C	0.4	Mouth	16,44N,5E	St. Louis			x	x			B			
Grand R.	P	127.5	19,23N,57W	State Line	Livingston	Worth	x	x	x			A	x	x	
Grand R.	P	56.0	Mouth	[Shoal Cr.] 19,57N,23W	Chariton	Livingston	x	x	x			A	x	x	
Graddaddy Cr.	C	1.5	Mouth	26,41N,28W	Henry			x	x			B			
Grandglaze Cr.	P	7.6	Mouth	24,38N,15W	Miller	Camden		x	x			A	x		
Granny Cr.	P	1.0	Mouth	6,30N,11E	Bollinger			x	x			B			
Granny Cr.	C	1.2	6,30N,11E	31,31N,11E	Bollinger			x	x			B			
Grantham Cr.	C	3.4	Mouth	2,64N,33W	Gentry			x	x						
Grassy Cr.	C	1.8	Mouth	10,54N,2W	Pike			x	x			B			
Grassy Cr.	C	2.4	Mouth	26,48N,22W	Saline	Pettis		x	x			B			
Grassy Cr.	C	19.8	Mouth	34,61N,8W	Marion	Lewis		x	x			B			
Grassy Cr.	C	5.0	20,30N,8E	14,30N,8E	Bollinger			x	x			B			
Grassy Cr.	P	1.3	Mouth	20,30N,8E	Bollinger			x	x			B			
Grassy Hollow	C	3.9	Mouth	[09,28N,07W] 9,28N,7W	Texas			x	x			B			
Graveyard Br.	C	0.9	Mouth	01,42N,09W	Osage			x	x			B			
Gravois Cr.	P	9.3	Mouth	20,42N,18W	Morgan			x	x			A	x		
Gravois Cr.	P	2.3	Mouth	[24,44N,6E]	St. Louis City	St. Louis		x	x			B			
Gravois Cr.	C	[6.0] 10.7	[24,44N,6E]	LG 3102,44N,6E 1,44N,5E	St. Louis			x	x			B			
Grays Cr.	P	13.8	Mouth	35,45N,13W	Cole			x	x			B			
Grays Cr.	C	1.0	35,45N,13W	34,45N,13W	Cole			x	x			B			
Greasy Cr.	C	1.5	Mouth	11,29N,3E	Wayne			x	x			B			
Greasy Cr.	P	4.2	Mouth	31,34N,19W	Dallas			x	x	x		B			
Greasy Cr.	C	11.5	31,34N,19W	11,32N,20W	Dallas			x	x	x		B	x		
Greasy Cr.	C	4.1	Mouth	23,35N,7E	St. Genevieve			x	x			B			
Greasy Cr.	C	4.2	Mouth	12,21N,29W	Barry			x	x			B			
Greasy Cr.	C	0.7	14,45N,08W	13,45N,08W	Osage			x	x			B			
Greasy Cr.	P	0.2	Mouth	14,45N,08W	Osage			x	x			B			
Greedy Cr.	C	[1.7] 1.3	[20,41N,06W] 21,41N,6W	[18,41N,06W] 18,41N,6W	Gasconade			x	x			B	x		
Greedy Cr.	P	0.8	Mouth	20,41N,06W	Gasconade			x	x			B			
Green Spring Br.	C	1.8	Mouth	[02,35N,25W] 2,35N,25W	St. Clair	Cedar		x	x			B			
Greenbriar Cr.	C	2.0	Mouth	27,24N,2W	Oregon			x	x			B			
Greens Cr.	C	0.7	Mouth	2,39N,2W	Crawford			x	x			B			
Greenwood Valley	C	1.9	Mouth	28,28N,3E	Wayne			x	x			B			
Greer Br.	C	6.6	Mouth	23,47N,21W	Pettis			x	x			B			
Greer Cr.	C	1.8	Mouth	25,31N,19W	Webster			x	x			B			
Greer Spring Br.	P	1.3	Mouth	36,25N,4W	Oregon			x	x		x	B			
Greggs Cr.	C	2.0	Mouth	Sur 2653,51N,17W	Howard			x	x			B			
Greys Lake	C	5.2	13,66N,42W	10,66N,42W	Atchison			x	x			B			
Grindstone Br.	C	6.0	Mouth	25,51N,13W	Boone			x	x			B			
Grindstone Cr.	P	17.9	Mouth	35,59N,30W	Daviess	DeKalb		x	x			A	x		
Grindstone Cr.	C	19.4	35,59N,30W	24,57N,31W	DeKalb	Clinton		x	x			B	x		
Grindstone Cr.	C	2.5	Mouth	20,48N,12W	Boone			x	x			A			

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Groshong Br.	C	1.5	Mouth	12,48N,1E	Lincoln			x	x			B			
Grounds Cr.	C	1.3	Mouth	4,32N,8E	Madison			x	x			B			
Grove Cr.	P	2.9	Mouth	1,27N,32W	Jasper			x	x			B			
Grove Cr.	C	3.3	Mouth	8,54N,33W	Platte			x	x			B			
Guinns Cr.	C	0.5	Mouth	30,52N,2E	Pike			x	x			B			
Gulley Spring Cr.	C	4.3	Mouth	5,21N,14W	Ozark			x	x			B			
Gum Spring Br.	C	0.5	[Hwy. W]	31,43N,11W	Cole			x	x			B			
[Gum Spring Cr.]	P	1.0	Mouth	32,43N,11W	Cole			x	x			B			
Gum Spring Br.				32,43N,11W											
Gunter Cr.	C	6.7	Mouth	29,24N,27W	Barry			x	x			B			
Hackberry Br.	C	4.5	Mouth	29,35N,32W	Vernon			x	x			B			
Haldiman Br.	C	3.0	Mouth	10,46N,14W	Monteau			x	x			B			
Half Moon Bayou	C	3.0	23,17N,12E	8,17N,13E	Pemiscot			x	x			B			
Halls Cr.	C	1.5	Mouth	18,46N,8W	Callaway			x	x			B			
Halsey Hollow	C	2.2	Mouth	2,35N,18W	Dallas			x	x			B			
Hamilton Cr.	P	4.5	Mouth	5,29N,10W	Texas			x	x			B			
Hamilton Cr.	C	2.0	5,29N,10W	7,29N,10W	Texas			x	x			B			
Hamilton Cr.	C	2.2	Mouth	29,40N,1W	Washington			x	x			B			
Hamilton Cr.	P	1.8	Mouth	14,44N,03E	St. Louis			x	x			B			
Hancock Hollow	C	1.0	Mouth	2,25N,21W	Christian			x	x			B			
Hankens Br.	C	1.0	Mouth	33,33N,20W	Dallas			x	x			B			
Harding Cr.	C	3.0	Mouth	15,43N,33W	Cass			x	x			B			
Harless Cr.	C	2.3	34,44N,33W	28,44N,33W	Cass			x	x			B			
Harpst Chute	P	5.5	Mouth	[30,54N,36W]	Platte			x	x			B			
				5,53N,36W											
Harris Br.	C	1.0	Mouth	18,39N,1W	Washington			x	x			B			
Harris Cr.	C	5.6	Mouth	34,23N,3E	Ripley			x	x			B			
Harrison Br.	P	1.0	Mouth	15,24N,33W	Newton			x	x			B			
Harrison Br.	C	1.7	15,24N,33W	23,24N,33W	Newton			x	x			B			
Harrison Br.	C	3.7	Mouth	32,49N,8W	Callaway			x	x			B			
Hart Cr.	C	3.2	Mouth	6,45N,12W	Boone			x	x			B			
Harviell Ditch (#3)	C	16.2	State Line	12,23N,5E	Ripley	Butler	x	x	x			B	x		
Haverstick Cr.	C	1.5	Mouth	29,40N,5E	Jefferson			x	x			[B]	x		
Haw Cr.	C	1.0	Mouth	33,40N,13W	Miller			x	x			B			
Haw Cr.	P	17.5	Mouth	6,42N,19W	Morgan			x	x			A	x		
Haw Cr.	C	1.5	6,42N,19W	12,42N,20W	Morgan	Benton		x	x			B			
Hawker Br.	C	2.5	16,33N,26W	18,33N,26W	Cedar			x	x			B			
Hawker Cr.	P	8.6	Mouth	16,29N,9E	Bollinger			x	x			B			
Hawker Cr.	C	1.5	16,29N,9E	8,29N,9E	Bollinger			x	x			B			
Hawn Cr.	C	0.9	Mouth	30,32N,9E	Bollinger			x	x			B			
Hayden Cr.	C	2.7	Mouth	7,36N,4E	St. Francois			x	x			B			
Hays Cr.	C	2.0	Mouth	29,54N,5W	Ralls			x	x			B			
Hayzlett Br.	P	2.4	Mouth	25,62N,37W	Nodaway			x	x			B			
Hazel Cr.	P	9.0	Mouth	20,36N,1E	Washington			x	x			B			
Hazel Cr.	C	2.2	20,36N,1E	15,36N,1E	Washington			x	x			B			
Hazel Cr.	C	5.6	Mouth	31,64N,15W	Adair			x	x			B			
Hazel Run	C	4.3	Mouth	35,38N,5E	St. Francois			x	x			B			

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Hazelton Spring	P	0.1	Mouth	34,33N,10W	Texas			x	x			B			
Heads Cr.	P	2.7	Mouth	3,42N,4E	Jefferson			x	x			B			
Heads Cr.	C	2.4	3,42N,4E	14,42N,4E	Jefferson			x	x			[B]	x		
Headwater Div. Chan.	P	20.3	Mouth	4,29N,11E	Cape Girardeau			x	x			A	x	x	
Heat String Cr.	C	1.3	Mouth	36,49N,8W	Callaway			x	x			B			
Heaths Cr.	P	21.0	Mouth	27,48N,21W	Cooper	Pettis		x	x	x		B			
Heath Cr.	C	11.5	[27,48N,22W] 27,48N,21W	17,47N,22W	Pettis			x	x	x		B			
Henderson Cr.	P	0.4	Mouth	32,33N,8E	Madison			x	x			B			
Henderson Cr.	C	1.7	32,33N,8E	30,33N,7E	Madison			x	x			B			
Henderson Hollow	C	0.9	Mouth	16,30N,4E	Iron			x	x			B			
Henpeck Hollow	C	2.2	Mouth	22,38N,2W	Crawford			x	x			B			
Henry Cr.	C	3.7	23,44N,22W	36,44N,22W	Pettis			x	x			B			
Henry Cr.	P	1.7	Mouth	23,44N,22W	Pettis			x	x			B			
Hess Cr.	C	3.1	Mouth	13,47N,22W	Pettis			x	x			B			
Hicklin Cr.	C	5.3	Mouth	12,34N,29W	Cedar			x	x			B			
Hickory Br.	C	6.8	Mouth	7,55N,20W	Chariton			x	x			B			
Hickory Cr.	C	1.0	Mouth	1,59N,38W	Holt			x	x			B			
Hickory Cr.	C	4.2	Mouth	20,37N,7E	Ste. Genevieve			x	x			B			
Hickory Cr.	C	6.6	Mouth	2,51N,6W	Audrain			x	x			B			
Hickory Cr.	C	2.7	Mouth	11,25N,6E	Butler			x	x			B			
Hickory Cr.	C	1.2	Mouth	21,61N,37W	Holt			x	x			B			
Hickory Cr.	P	4.9	Mouth	28,25N,31W	Newton			x	x			A			
Hickory Cr.	C	1.5	Mouth	11,61N,34W	Andrew			x	x			B			
Hickory Cr.	C	2.8	Mouth	11,60N,28W	Daviess			x	x			B			
Hickory Cr.	P	3.0	Mouth	22,61N,31W	Gentry			x	x			B			
Hickory Cr.	C	10.9	Mouth	9,60N,25W	Grundy			x	x			B			
Hickory Flat Cr.	P	1.0	Mouth	6,27N,7E	Wayne			x	x			B			
Higgins Cr.	C	1.3	Mouth	34,43N,12W	Cole			x	x			B			
High Cr.	C	6.3	20,66N,41W	13,66N,41W	Atchison			x	x			B			
High Cr. Ditch	C	3.7	22,66N,42W	20,66N,41W	Atchison			x	x			B			
Highly Cr.	C	3.9	Mouth	7,62N,37W	Holt			x	x			B			
Hightower Cr.	C	5.1	Mouth	30,37N,30W	Vernon			x	x			B			
Hillers Cr.	P	5.8	Mouth	[32,45N,9W] LG 2674,45N,9W	Callaway			x	x			B			
Hillers Cr.	C	12.8	[32,45N,9W] LG 2674,45N,9W	34,46N,10W	Callaway			x	x			B			
Hinch Br.	P	1.5	Mouth	33,39N,2W	Crawford			x	x			B			
Hinch Br.	C	1.9	33,39N,2W	4,38N,2W	Crawford			x	x			B			
Hinkson Cr.	P	7.6	Mouth	Hwy. 163	Boone			x	x			B	x		
Hinkson Cr.	C	18.8	Hwy. 163	36,50N,12W	Boone			x	x			[B]	x		
Hippo Br.	C	2.3	Mouth	7,54N,5W	Ralls			x	x			B			
Hocum Hollow	C	0.5	Mouth	[Sur 1856,40N,6E] LG 1856,40N,6E	Jefferson			x	x			B			
Hodge Cr.	C	[2.0/2.2]	28,32N,4W	16,32N,4W	Dent			x	x			B			
Hog Cr.	P	5.1	Mouth	06,29N,9W	Texas			x	x	x		B			
Hog Cr.	C	4.4	06,29N,9W	16,29N,09W	Texas			x	x			B			

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Hog Cr.	C	6.5	Mouth	18,62N,16W	Adair			x	x			B			
Hog Cr.	C	1.9	14,31N,10E	3,31N,10E	Bollinger			x	x			A			
Hog Cr.	P	9.4	Mouth	14,31N,10E	Cape Girardeau	Bollinger		x	x			B			
Hogan Fk.	C	5.8	Mouth	17,44N,26W	Johnson			x	x					x	
Hogard Cr.	C	1.3	Mouth	1,22N,14W	Ozark			x	x			B			
Hogles Cr.	P	17.8	Mouth	5,37N,23W	Benton	Hickory		x	x	x		B			
Hogles Cr.	C	6.4	5,37N,23W	34,37N,23W	Hickory			x	x	x		B			
Holland Br.	C	3.0	Mouth	10,54N,34W	Platte			x	x			B			
Holtzclaw Cr.	C	2.0	Mouth	15,53N,32W	Clay			x	x			B			
[Homes Cr.]	C	[5.2/5.4]	Mouth	[Hwy 33]	Clay			x	x			B			
Holmes Cr.				15,52N,31W											
Hominy Br.	C	1.0	Mouth	17,48N,12W	Boone			x	x			B		x	
Hominy Cr.	P	13.2	Mouth	15,33N,21W	Polk			x	x			B			
Honey Cr.	C	8.5	Mouth	24,43N,27W	Henry			x	x			B			
Honey Cr.	P	16.5	Mouth	22,27N,25W	Lawrence			x	x			B			
Honey Cr.	C	2.7	22,27N,25W	35,27N,25W	Lawrence			x	x			B			
Honey Cr.	P	2.6	State Line	State Line	McDonald		x	x	x			A			
Honey Cr.	P	12.2	Mouth	1,65N,34W	Nodaway			x	x			B			
Honey Cr.	C	6.7	1,65N,34W	18,66N,33W	Nodaway			x	x			B			
Honey Cr.	PI	7.0	Mouth	[33,64N,6W]	Clark			x	x			B		x	
Honey Cr.	C	15.0	[Hwy 61]	[Hwy 81]	Clark			x	x			B			
Honey Cr.	C	8.3	32,64N,6W	6,64N,7W											
Honey Cr.	C	25.1	Mouth	35,59N,28W	Daviess			x	x			B			
Honey Cr.	C	2.6	Mouth	29,63N,23W	Livingston	Grundy		x	x			B			
Honey Cr.	C	2.6	Mouth	13,46N,19W	Cooper			x	x			B			
Honey Cr.	C	7.0	Mouth	14,47N,27W	Johnson			x	x			B			
Honey Cr.	C	4.6	Mouth	29,43N,12W	Cole			x	x			B		x	
Honey Cypress Ditch	P	14.7	Mouth	27,18N,8E	Dunklin			x	x			B			
Honey Run	C	1.7	Mouth	6,38N,15W	Camden			x	x			B			
Hoosier Cr.	C	2.2	Mouth	11,41N,1W	Franklin			x	x			B		x	
Hoover Cr.	C	7.2	Mouth	1,55N,14W	Macon	Randolph		x	x			B			
Hope Cr.	C	1.7	Mouth	35,44N,7W	Osage			x	x			B			
Hopewell Cr.	C	1.0	Mouth	3,36N,3E	Washington			x	x			B			
Hopewell Cr.	C	1.6	Mouth	33,46N,2W	Warren			x	x			A		x	
Horrell Cr.	P	3.0	Mouth	[Sur 233,32N,12E]	Cape Girardeau			x	x			B			
				LG 233,32N,12E											
Horrell Cr.	C	1.7	Sur 233, 32N12E	2,32N,12E	Cape Girardeau			x	x			[B]		x	
Horse Cr.	P	27.7	Mouth	35,34N,29W	Cedar	Vernon	x	x	x			B			
Horse Cr.	C	34.6	35,34N,29W	15,31N,28W	Vernon	Dade		x	x			B			
Horse Cr.	C	2.0	Mouth	26,25N,23W	Stone			x	x			B			
Horse Fk.	C	4.4	Mouth	6,55N,31W	Clifton			x	x			B			
Horseshoe Cr.	C	5.8	Mouth	10,48N,29W	Jackson	Lafayette		x	x			B			
Horstman Cr.	C	2.0	Mouth	7,45N,4W	Gasconade			x	x			B			
Houfs Cr.	C	1.6	Mouth	27,48N,9W	Callaway			x	x			B			
Housgen Cr.	C	0.9	Mouth	2,44N,9W	Osage			x	x			B			
Howard Cr.	C	4.3	Mouth	2,46N,15W	Moniteau			x	x			B			
Howell Cr.	C	16.8	Mouth	22,24N,8W	Oregon	Howell		x	x			B			

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Hubble Cr.	P	15.0	Mouth	Sur 2250,31N,12E	Cape Girardeau			x	x			B			
Hubble Cr.	C	2.5	Sur	2250,31N,12E	Cape Girardeau			x	x			B	x		
Hubble Cr.	P	1.5	Mouth	[23,29N,5E]	Wayne			x	x			B			
Hubble Cr.	C	2.0	[23,29N,5E]	LG 813,29N,5E	Wayne			x	x			B			
			LG 813,29N,5E												
Hudson Cr.	C	4.5	Mouth	11,25N,28W	Barry			x	x			B	x		
Huff Cr.	C	2.0	Mouth	[6,69N,37W]	Nodaway			x	x			B			
				6,64N,37W											
Huffstetter Lateral	P	12.0	6,23N,11E	16,25N,11E	Stoddard			x	x			B			
Hughes Cr.	P	3.0	Mouth	15,33N,12E	Cape Girardeau			x	x			B			
Hughes Cr.	C	2.9	15,33N,12E	20,33N,12E	Cape Girardeau			x	x			B			
Huldy Hollow	C	2.0	Mouth	[28,31N,07W]	Texas			x	x				x		
				28,31N,7W											
Humphrey Cr.	P	1.2	Mouth	1,40N,13W	Miller			x	x			B			
Hungry Cr.	C	2.1	Mouth	5,27N,11W	Douglas			x	x			B			
Hungry Mother Cr.	C	9.5	Mouth	18,51N,14W	Howard			x	x			B			
Hunke Cr.	C	1.8	Mouth	33,43N,06W	Gasconade			x	x			B			
Hunt Br.	P	0.5	22,28N,21W	22,28N,21W	Greene			x	x			B			
Hunt Br.	P	1.0	23,28N,21W	24,28N,21W	Greene			x	x			B			
Hunter Cr.	P	10.2	Mouth	6,26N,15W	Douglas			x	x			A	x		
Hunter Cr.	C	3.2	Mouth	20,30N,6E	Wayne			x	x			B			
Hurricane Br.	C	1.8	Mouth	27,59N,26W	Daviess			x	x			B			
Hurricane Cr.	P	1.9	Mouth	30,24N,12W	Ozark			x	x		x	B			
Hurricane Cr.	P	3.4	Mouth	28,25N,3W	Oregon			x	x			A	x		
Hurricane Cr.	C	6.1	28,25N,3W	4,25N,3W	Oregon			x	x			B			
Hurricane Cr.	C	6.0	Mouth	Hwy. 21	Ripley			x	x			B			
Hurricane Cr.	C	6.2	Mouth	35,55N,22W	Carroll			x	x			B			
Hurricane Cr.	C	3.8	Mouth	23,51N,17W	Howard			x	x			B	x		
Hurricane Cr.	P	12.4	Mouth	35,32N,9E	Bollinger			x	x			A			
Hutchins Cr.	P	4.5	Mouth	11,34N,4W	Dent			x	x			B			
Huzzah Cr.	P	35.8	Mouth	1,34N,3W	Crawford	Dent		x	x	x		A	x		
Huzzah Cr.	P	1.0	Mouth	31,31N,6E	Madison			x	x			B			
Hyatts Cr.	P	2.5	Mouth	2,31N,2E	Reynolds			x	x			B			
Hyde Cr.	P	4.4	Mouth	33,31N,16W	Webster			x	x			B			
Imboden Fk.	P	6.4	Mouth	27,34N,2E	Reynolds	Iron		x	x			B			
Indian Br.	C	3.8	Mouth	22,58N,25W	Livingston			x	x			B			
Indian Camp Cr.	P	3.3	Mouth	6,47N,1E	St. Charles			x	x			B			
Indian Camp Cr.	C	3.5	2,47N,1W	4,47N,1W	St. Charles	Warren		x	x			B	x		
Indian Cr.	C	3.3	Mouth	3,55N,8W	Monroe			x	x			B			
Indian Cr.	C	3.0	Mouth	5,41N,16W	Morgan			x	x			A	x		
Indian Cr.	P	7.7	Mouth	21,42N,20W	Benton			x	x	x		B			
Indian Cr.	C	1.2	Mouth	22,42N,8W	Osage			x	x			B			
Indian Cr.	P	3.7	Mouth	30,30N,9W	Texas			x	x			B			
Indian Cr.	C	2.7	30,30N,9W	27,30N,9W	Texas			x	x			B	x		
Indian Cr.	C	3.6	Mouth	Sur 2062,38N,8E	Ste. Genevieve			x	x			B	x		
Indian Cr.	C	20.0	Mouth	17,52N,4W	Pike			x	x			B			

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Indian Cr.	P	8.1	Mouth	10,32N,13E	Cape Girardeau			x	x			B			
Indian Cr.	P	1.0	Mouth	35,35N,3W	Crawford			x	x			B			
Indian Cr.	C	2.0	35,35N,3W	34,35N,3W	Crawford	[Dent]		x	x			B			
Indian Cr.	P	1.9	Mouth	18,35N,1W	Washington			x	x			B			
Indian Cr.	P	21.4	Mouth	36,39N,01W	Franklin	Washington		x	x		x	B			
Indian Cr.	C	3.4	36,39N,1W	8,38N,1E	Washington			x	x	x		B			
Indian Cr.	C	2.1	Mouth	[28,21N,24W]	Stone			x	x			B			
Indian Cr.	P	10.0	Mouth	35,27N,11W	Douglas			x	x			B			
Indian Cr.	C	7.5	35,27N,11W	22,27N,10W	Douglas	Howell		x	x			B			
Indian Cr.	P	6.1	Mouth	7,25N,7E	Butler			x	x			B			
Indian Cr.	C	1.6	7,25N,7E	6,25N,7E	Butler			x	x			B			
Indian Cr.	P	5.5	Mouth	5,34N,4E	St. Francois			x	x			A			
Indian Cr.	P	30.8	Mouth	24,24N,31W	McDonald	Newton	x	x	x	x		A	x		
Indian Cr.	C	0.8	Mouth	[28,40N,09W]	Maries			x	x			B			
Indian Cr.	C	0.2	Mouth	28,40N,9W	Osage			x	x			B			
Indian Cr.	C	2.4	Mouth	28,43N,9W	Osage			x	x			B			
Indian Cr.	C	3.4	Mouth	State Line	Jackson			x	x			A			x
Indian Cr.	C	3.2	Mouth	8,64N,32W	Gentry			x	x			B			
Indian Cr.	C	4.3	Mouth	17,66N,26W	Harrison			x	x			B			
Indian Cr.	C	3.5	Mouth	9,64N,11W	Scotland			x	x			B			
Indian Cr.	P	1.3	Mouth	9,31N,9E	Bollinger			x	x			B			
Indian Cr.	C	0.7	9,31N,9E	4,31N,9E	Bollinger			x	x			B			
Ingalls Cr.	C	6.8	Mouth	01,35N,21W	Hickory			x	x			B			
Iowa Ditch	P	2.8	Mouth	State Line	Atchison			x	x			B			
Ironton Hollow	C	0.9	Mouth	33,34N,4E	Iron			x	x			B			
Irvins Br.	C	3.3	Mouth	10,59N,30W	DeKalb			x	x			B			
Irvin Cr.	C	7.0	Mouth	State Line	Mercer			x	x			B			
Ishmael Br.	C	[1.4]0.9	Mouth	[9,36N,1E]	Washington			x	x			B			
Ishmael Br.	C	0.5	17,36N,1E	17,36N,1E	Washington			x	x			B			
Island Cr.	C	8.9	Mouth	6,61N,32W	Gentry			x	x			B			
Isle du Bois Cr.	P	4.5	Mouth	[18,39N,7E]	Ste. Genevieve			x	x			B			
Isle du Bois Cr.	C	2.3	[18,39N,7E]	14,39N,6E	Ste. Genevieve			x	x			B			
Isom Cr.	C	0.5	Mouth	30,42N,04E	Jefferson			x	x			B			
Jack Buster Cr.	P	1.5	Mouth	10,41N,14W	Miller			x	x			B			
Jack Cr.	C	0.8	Mouth	19,33N,10E	Bollinger			x	x			B			
Jacks Cr.	C	0.2	Mouth	23,37,18W	Camden			x	x			B	x		
Jacks Fk.	P	[61.6]46.4	Mouth	29,28N,7W	Shannon	Texas		x	x	x		A	x		
Jacktar Hollow	C	5.1	Mouth	22,32N,10W	Texas			x	x			B			
Jacobs Br.	P	1.6	Mouth	2,26N,33W	Newton			x	x			B			
Jakes Cr.	C	11.3	Mouth	24,35N,19W	Dallas			x	x			B			
Jam Up Cr.	P	3.0	Mouth	16,27N,6W	Shannon			x	x			B			
Jam Up Cr.	C	1.8	16,27N,6W	20,27N,6W	Shannon			x	x			B			

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James Bayou	C	3.5	12,23N,16E	26,23N,16E	Mississippi			x	x			B			
James Bayou	C	5.5	12,23N,16E	28,24N,16E	Mississippi			x	x			B			
James Bayou	C	5.8	2,24N,16E	2,25N,16E	Mississippi			x	x			B			
James Br.	P	1.5	Mouth	23,35N,3W	Crawford			x	x			B			
James Br.	C	1.9	23,35N,3W	28,35N,3W	Crawford			x	x			B			
[James Cr.]	C	2.5	Mouth	17,35N,2E	Washington			x	x			B			
Janes Cr.															
James R.	P	29.4	Mouth	8,26N,22W	Stone		x	x	x	x		A	x		
James R.	P	23.5	8,26N,22W	Lk. Springfd. Dam	Stone	Greene	x	x	x	x		A	x		
James R.	P	39.0	Mouth	24,29N,17W	Greene	Webster		x	x	x		A	x	x	
Jarvis Hollow	C	1.3	Mouth	23,38N,17W	Camden			x	x			B			
Jemerson Cr.	C	3.4	Mouth	29,46N,12W	Boone			x	x			B			
Jenkins Cr.	C	3.0	Mouth	1,24N,26W	Barry			x	x			B			
Jenkins Cr.	C	7.2	Mouth	8,62N,36W	Nodawny			x	x			B			
Jenkins Cr.	P	2.8	Mouth	7,27N,30W	Jasper			x	x			A			
Jenkins Cr.	C	4.8	7,27N,30W	22,27N,30W	Jasper	Newton		x	x			A			
Jerktail Br.	C	0.5	Mouth	11,34N,19W	Dallas			x	x			B			
Jesse Cr.	P	0.7	Mouth	21,29N,8E	Bollinger			x	x			B			
Jesse Cr.	C	2.0	21,29N,8E	9,29N,8E	Bollinger			x	x			B			
Joachim Cr.	P	30.2	Mouth	30,39N,5E	Jefferson			x	x			A	x		x
Joachim Cr.	C	[2.5/4.2	30,39N,5E	[4,38N,5E]	Jefferson			x	x			A			
Joes Cr.	C	1.0	Mouth	23,34N,1E	Iron	St. Francois		x	x			B			
Johns Br.	C	1.3	Mouth	32,51N,4W	Pike			x	x			B			
Johns Br.	C	2.9	18,27N,8E	11,27N,7E	Wayne			x	x			B			
Johns Cr.	C	1.0	Mouth	6,35N,9E	Ste. Genevieve			x	x			B			
Johns Cr.	P	1.4	Mouth	22,36N,1W	Washington			x	x			B			
Johns Cr.	C	2.0	22,36N,1W	27,36N,1W	Washington			x	x			B			
Johnson Br.	C	1.0	Mouth	29,30N,9W	Texas			x	x				x		
Johnson Cr.	P	3.0	Mouth	36,29N,26W	Lawrence			x	x		x	A			
Johnson Hollow	C	1.0	Mouth	13,27N,20W	Christian			x	x			B			
Jonca Cr.	P	[3.5/3.3	Mouth	36,37N,7E	Ste. Genevieve			x	x			B			
Jonca Cr.	C	6.0	36,37N,7E	8,36N,7E	Ste. Genevieve			x	x			B			
Jones Br.	C	3.2	Mouth	32,33N,19W	Dallas			x	x			B			
Jones Cr.	C	[3.0/3.7	Mouth	8,32N,18W	Dallas			x	x			[B]	x		
Jones Cr.	C	8.0	Mouth	27,38N,11W	Pulaski			x	x			A			
Jones Cr.	P	3.5	Mouth	15,41N,03E	Jefferson			x	x			B			
Jones Cr.	P	7.5	Mouth	30,27N,30W	Jasper	Newton		x	x	x		A			
Jones Cr.	C	4.0	Mouth	4,42N,16W	Morgan			x	x			B			
[Jordan Br.]	C	1.2	Mouth	13,30N,26W	Dade			x	x			B			
Jordan Cr.															
Jordan Br.	C	2.2	Mouth	15,37N,22W	Hickory			x	x			B			
Jordan Br.	C	1.8	Mouth	32,35N,9E	Perry			x	x			B			
Jordan Br.	C	7.2	Mouth	32,55N,35W	Platte	Buchanan		x	x			B			
Jordan Cr.	C	1.4	Mouth	10,57N,33W	DeKalb			x	x			B			
Jordan Cr.	P	3.8	Mouth	[23,29N,22W]	Greene			x	x			B			
Jordan Cr.															
Jordan Cr.	C	3.5	Mouth	13,29N,22W	Saline			x	x			B			
Jordan Cr.															

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Jowler Cr.	C	8.9	Mouth	19,54N,34W	Platte			x	x			B			
Joyce Cr.	C	[4.5]/5.0	Mouth	16,24N,28W	Barry			x	x			B			
Judge Cr.	C	3.0	Mouth	19,36N,19W	Dallas			x	x			B			
Kaintuck Hollow Cr.	P	2.4	Mouth	[15,36N,09W]	Phelps			x	x			B			
				15,36N,9W											
Keelstone Br.	C	1.0	Mouth	2,48N,1E	Lincoln			x	x			B			
Keeney Cr.	C	4.9	Mouth	13,51N,29W	Ruy			x	x			[B]	x		
[Kiefer Cr.]	P	1.2	Mouth	[15,44N,04E]	St. Louis			x	x			[B]			
Kiefer Cr.				LG 1997,44N,4E											
Kelley Br.	C	1.3	Mouth	25,50N,13W	Boone			x	x			B			
Kelley Br.	C	5.8	Mouth	15,50N,12W	Boone			x	x				x		
Kelley Br.	C	0.8	Mouth	1,44N,17W	Moniteau			x	x			B			
Kelley Valley	C	2.7	Mouth	23,27N,3E	Wayne			x	x			B			
Kelley Valley	P	1.0	23,27N,3E	26,27N,3E	Wayne	Carter		x	x			B			
Kelly Hollow	C	1.0	Mouth	3,35N,1W	Washington			x	x			B			
Kelly Hollow	P	1.3	Mouth	26,25N,3W	Oregon			x	x			B			
Kenser Cr.	C	2.0	Mouth	22,39N,12W	Miller			x	x			B			
Kessler Cr.	C	2.2	Mouth	21,34N,6E	Madison			x	x			B			
Ketchum Hollow	C	1.9	Mouth	24,22N,27W	Barry			x	x				x		
Kettle Cr.	C	0.8	Mouth	31,58N,26W	Daviess			x	x			B			
Kile Cr.	C	1.3	Mouth	28,51N,13W	Boone			x	x			B			
Kimsey Cr.	P	0.8	Mouth	[19,59N,39W]	Holt			x	x			B			
				7,59N,38W											
Kimsey Cr.	[C P]	2.5	[19,59N,38W]	30,60N,38W	Holt			x	x			[B]	x		
			7,59N,38W												
Kimsey Cr.	P	6.7	30,60N,38W	34,61N,38W	Holt			x	x			B			
King Br.	C	[1.5]/4.5	Mouth	[23,31N,22W]	Greene			x	x			B			
				2,30N,22W											
[King Br.]	[C]	[1.8]	[35,31N,22W]	[2,30N,22W]	[Greene]			[x]	[x]			[B]			
Kings R.	P	1.6	Mouth	State Line	Barry	Stone		x	x			A	x		
Kings Valley	P	3.3	Mouth	33,23N,30W	McDonald			x	x			B			
Kinnemore Ditch	C	13.0	State Line	5,17N,8E	Dunklin			x	x			B			
Kinsey Cr.	P	2.7	Mouth	33,39N,7E	Ste. Genevieve			x	x			B			
Kitten Cr.	C	7.2	Mouth	34,37N,29W	St. Clair	Vernon		x	x			B			
Knob Cr.	C	8.4	Mouth	8,41N,32W	Bates			x	x				x		
Knob Cr.	C	2.2	Mouth	30,34N,4E	Iron			x	x			B			
Knobby Cr.	P	1.5	Mouth	34,40N,20W	Benton			x	x			B			
Knobby Cr.	C	1.0	34,40N,20W	3,39N,20W	Benton			x	x			B			
Knox Br.	C	1.0	Mouth	33,38N,1E	Washington			x	x			B			
Koen Cr.	C	1.0	Mouth	5,36N,5E	St. Francois			x	x			B	x		
Kolb Br.	C	1.6	Mouth	3,38N,19W	Camden			x	x			B			
Kraut Run	P	0.4	Mouth	LG 56,46N,2E	St. Charles			x	x			B			
Kriete Cr.	C	1.5	Mouth	15,42N,4W	Franklin			x	x			B			
Krone Br.	C	1.1	Mouth	29,40N,10W	Maries			x	x			B			
Kruze Cr.	P	0.9	Mouth	[36,41N,03E]	Jefferson			x	x			B			
				36,41N,2E											
Kruze Cr.	P	0.1	Mouth	31,41N,3E	Jefferson			x	x			B			
Kyle Cr.	C	8.4	Mouth	34,31N,28W	Barton	Dade		x	x			B			
L. Alder Cr.	C	1.6	Mouth	5,35N,27W	Cedar			x	x			B			

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WATER BODY	CLASS	MILES	FROM	TO	COUNTY	COUNTY 2	IRR	LWW	AQL	CLF	CDF	WBC	SCR	DWS	IND
L. Apple Cr.	P	4.6	Mouth	13,33N,11E	Cape Girardeau			x	x			B			
L. Apple Cr.	C	1.2	13,33N,11E	24,33N,11E	Cape Girardeau			x	x			B			
L. Bear Cr.	C	1.2	Mouth	25,40N,15W	Miller			x	x			[B]	x		
L. Bear Cr.	C	1.0	Mouth	2,46N,5W	Montgomery			x	x			B			
L. Bear Cr.	C	4.0	Mouth	8,48N,3W	Montgomery			x	x			B	x		
L. Beaver Cr.	C	3.5	Mouth	8,37N,8W	Phelps			x	x			A			
L. Beaver Cr.	P	10.4	Mouth	36,26N,18W	Taney	Douglas	x	x	x			A	x		
L. Beaver Cr.	C	4.5	36,26N,18W	17,26N,17W	Douglas			x	x			B			
L. Berger Cr.	P	5.0	Mouth	17,45N,4W	Franklin	Gasconade		x	x			B			
L. Berger Cr.	C	1.2	17,45N,4W	19,45N,4W	Gasconade			x	x			B			
L. Black R.	P	30.2	State Line	31,24N,5E	Ripley	Butler	x	x	x			A	x		
L. Black R.	P	16.0	31,24N,5E	9,24N,3E	Butler	Ripley	x	x	x	x		A	x		
L. Blackwater Cr.	C	6.0	Mouth	36,47N,28W	Johnson			x	x			B			
L. Blair Cr.	C	2.0	Mouth	6,29N,2W	Shannon			x	x			B			
L. Blue R.	P	35.1	Mouth	Longview Dam	Jackson			x	x			B	x		
L. Blue R.	C	4.3	20,47N,32W	35,47N,33W	Jackson			x	x			B	x		
L. Boeuf Cr.	P	0.6	Mouth	2,44N,2W	Franklin			x	x			B			
L. Boeuf Cr.	C	2.8	2,44N,2W	[14,44N,2W] 15,44N,2W	Franklin			x	x			B			
L. Bonne Femme Cr.	P	9.0	Mouth	1,47N,13W	Boone			x	x			B			
L. Boone Cr.	C	2.0	Mouth	22,41N,3W	Franklin			x	x			B			
L. Bottom Cr.	C	0.6	Mouth	31,38N,8E	Ste. Genevieve			x	x			B			
L. Bourbeuse Cr.	C	9.6	Mouth	20,39N,7W	Phelps	Maries		x	x			B			
L. Bourbeuse R.	P	13.4	Mouth	26,40N,4W	Franklin	Crawford		x	x			B			
L. Bourbeuse R.	C	3.0	26,40N,4W	3,39N,4W	Crawford			x	x			[B]	x		
L. Brazil Cr.	P	2.1	Mouth	18,38N,1W	Washington			x	x			B			
L. Brazil Cr.	C	1.0	18,38N,1W	19,38N,1W	Washington			x	x			B			
L. Brush Cr.	C	7.0	Mouth	10,59N,17W	Macon			x	x			B			
L. Brushy Cr.	C	2.0	Mouth	18,27N,4E	Wayne			x	x			B			
L. Buffalo Cr.	P	5.6	Mouth	11,41N,19W	Morgan			x	x			B			
L. Calumet Cr.	P	1.4	Mouth	2,53N,1W	Pike			x	x			B			
L. Calumet Cr.	C	1.4	2,53N,1W	10,53N,1W	Pike			x	x			B			
L. Calvey Cr.	C	1.0	Mouth	9,42N,2E	Franklin			x	x			B	x		
L. Cane Cr.	C	3.4	State Line	26,22N,5E	Butler		x	x	x			B			
L. Cedar Cr.	C	2.0	17,48N,11W	[05,48N,11W] 5,48N,11W	Boone			x	x			B			
L. Cedar Cr.	C	4.6	Mouth	17,48N,11W	Boone			x	x			B			
L. Chariton R.	P	12.9	Mouth	5,52N,17W	Chariton			x	x			B			
L. Clear Cr.	C	1.3	Mouth	8,34N,30W	Vernon			x	x			B			
L. Clear Cr.	C	5.0	Mouth	1,36N,28W	St. Clair			x	x			B			
L. Coon Cr.	C	4.0	Mouth	6,30N,29W	Barton			x	x			B			
L. Courtois Cr.	P	2.0	Mouth	2,39N,1W	Washington			x	x			B			
L. Courtois Cr.	C	2.0	2,39N,1W	15,39N,1W	Washington			x	x			B			
L. Crane Cr.	C	6.0	Mouth	4,25N,25W	Stone	Barry		x	x			B	x		
L. Crooked Cr.	C	4.7	Mouth	20,57N,11W	Shelby			x	x			B			
L. Crooked Cr.	P	3.2	Mouth	33,31N,9E	Bollinger			x	x			A			
L. Crooked Cr.	C	2.7	33,31N,9E	32,31N,9E	Bollinger			x	x			B			
L. Dardenne Cr.	C	[7-4]/4.1	Mouth	10,46N,1E	St. Charles			x	x			B			

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L. Deer Cr.	C	9.0	Mouth	[01,38N,21W] 1,38N,21W	Benton			x	x			[B]	x		
L. Deer Cr.	C	3.7	Mouth	31,42N,30W	Bates			x	x			B	x		
L. Dry Fk.	P	5.2	Mouth	17,37N,7W	Phelps			x	x			B	x		
L. Dry Fk.	C	4.7	17,37N,7W	5,36N,7W	Phelps			x	x			B			
L. Dry Wood Cr.	P	20.5	Mouth	12,34N,32W	Vernon			x	x			B			
L. Dry Wood Cr.	C	15.6	12,34N,32W	20,33N,31W	Vernon	Barton		x	x			B			
L. E. Fk. Locust Cr.	C	8.8	Mouth	30,62N,19W	Sullivan			x	x			B			
L. Fabius R.	C	36.4	Mouth	17,61N,12W	Knox			x	x			B	x		
L. Finley Cr.	P	5.5	Mouth	5,28N,17W	Webster			x	x			B			
L. Flat Cr.	P	3.9	Mouth	25,25N,27W	Barry			x	x		x	A	x		
L. Flat Cr.	C	[2.7/7.3	25,25N,27W	[34,25N,27W] 11,24N,28W	Barry			x	x			B	x		
L. Flora Cr.	P	3.4	Mouth	Sur 2201,31N,14E	Cape Girardeau			x	x			B			
L. Fourche a Renault Cr.	P	1.0	Mouth	26,38N,1E	Washington			x	x			B			
L. Fourche a Renault Cr.	C	2.8	26,38N,1E	2,37N,1E	Washington			x	x			B			
L. Fox Cr.	P	0.7	Mouth	31,44N,03E	St. Louis			x	x			B			
L. Fox R.	P	19.8	Mouth	34,67N,10W	Clark	Scotland		x	x			B			
L. Fox R.	C	3.7	34,67N,10W	19,67N,10W	Scotland			x	x			B			
L. Gravois Cr.	P	4.2	Mouth	1,40N,16W	Miller			x	x			A			
L. Gravois Cr.	C	3.0	1,40N,16N	30,41N,15W	Miller			x	x			B			
L. Gravois Cr.	P	4.0	Mouth	21,42N,17W	Morgan			x	x			A	x		
L. Hazel Cr.	P	1.5	Mouth	29,36N,1E	Washington			x	x			B			
L. Hazel Cr.	C	0.5	29,36N,1E	32,36N,1E	Washington			x	x			B			
L. Hogles Cr.	P	1.2	Mouth	[09,39N,23W] 9,39N,23W	Benton			x	x			B			
L. Hogles Cr.	C	1.7	09,39N,23W	16,39N,23W	Benton			x	x			B			
L. Horseshoe Cr.	C	5.1	Mouth	11,48N,29W	Jackson	Lafayette		x	x			[B]	x		
L. Hunting Slough	C	5.0	Mouth	14,22N,6E	Butler		x	x	x			B			
L. Hurricane Cr.	C	4.0	Mouth	7,24N,3W	Oregon			x	x			B			
L. Hurricane Cr.	C	1.6	Mouth	1,54N,22W	Carroll			x	x			B			
L. Indian Cr.	P	2.7	Mouth	19,32N,14E	Cape Girardeau			x	x			B			
L. Indian Cr.	C	2.0	19,32N,14E	25,32N,13E	Cape Girardeau			x	x			B			
L. Indian Cr.	P	8.7	Mouth	30,40N,2E	Franklin	Washington		x	x			B			
L. Indian Cr.	C	1.0	30,40N,2E	31,40N,2E	Washington			x	x			B	x		
L. Lake Cr.	C	5.1	Mouth	31,29N,5E	Wayne			x	x			B			
L. Lead Cr.	C	4.0	27,50N,2W	20,50N,2W	Lincoln			x	x			B			
L. Lindley Cr.	C	3.7	Mouth	15,34N,20W	Dallas			x	x			B	x		
L. Lost Cr.	C	1.5	Mouth	18,46N,3W	Warren			x	x			B			
L. Lost Cr.	P	1.7	Mouth	26,37N,1W	Washington			x	x			B			
L. Lost Cr.	P	5.8	Mouth	28,25N,33W	Newton			x	x			B			
L. Loutre Cr.	C	10.3	Mouth	5,49N,6W	Montgomery			x	x			B	x		
L. Maries Cr.	P	8.5	Mouth	24,42N,11W	Osage			x	x	x		B			
L. Maries Cr.	C	1.0	24,42N,11W	23,42N,11W	Osage			x	x			B			
L. Maries R.	P	6.9	Mouth	12,40N,11W	Maries			x	x			B			
L. Maries R.	C	12.3	12,40N,11W	[28,39N,11W] 4,38N,11W	Maries			x	x			B			
L. Medicine Cr.	P	39.8	Mouth	State Line	Grundy	Mercer		x	x			B			

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L. Meramec R.	P	3.5	Mouth	[7,41N,2E]	Franklin			x	x			B			
[L. Meramec R.]	[P]	[2.0]	[7,41N,2E]	[8,41N,2E]	[Franklin]			[x]	[x]			[B]			
L. Meramec R.	C	1.2	8,41N,2E	16,41N,2E	Franklin			x	x			B	x		
L. Mill Cr.	P	5.9	Mouth	33,38N,21W	Hickory			x	x			B			
L. Monegaw Cr.	C	9.0	Mouth	36,39N,27W	St. Clair			x	x			B			
L. Moniteau Cr.	P	3.3	Mouth	3,45N,14W	Moniteau			x	x			A			
L. Moniteau Cr.	C	5.1	3,45N,14W	18,45N,14W	Moniteau			x	x			B			
L. Muddy Cr.	P	2.0	Mouth	[Sur 2219,32,10E]	Cape Girardeau	Bollinger		x	x			B			
L. Muddy Cr.	C	6.8	Sur 2219,32N,10E	Sur 3144,33N,10E	Bollinger			x	x			B	x		
L. Muddy Cr.	C	4.1	Mouth	17,60N,27W	Daviess			x	x			B			
L. Muddy Cr.	C	7.1	Mouth	State Line	Mercer			x	x			B			
L. Muddy Cr.	C	7.5	Mouth	18,46N,22W	Pettis			x	x			B			
L. Mussel Cr.	C	4.4	Mouth	17,61N,17W	Adair			x	x			B			
L. N. Fk. White R.	P	8.9	Mouth	36,24N,16W	Ozark			x	x	x		B			
L. N. Fk. White R.	C	6.9	36,24N,16W	3,24N,16W	Ozark			x	x	x		B			
L. N. Fork	C	15.1	Mouth	30,31N,32W	Jasper	Barton	x	x	x			B			
L. Niangua R.	P	43.8	Mouth	26,36N,19W	Camden	Dallas		x	x	x		A	x		
L. Niangua R.	C	8.0	26,36N,19W	20,35N,19W	Dallas			x	x			A	x		
L. No Cr.	C	4.9	Mouth	30,63N,22W	Grundy			x	x			B			
L. Noix Cr.	C	1.7	Mouth	28,54N,2W	Pike			x	x			[B]	x		
L. Osage R.	P	[27.4] 19.0	[19,38N,29W]	18,37N,31W	Vernon			x	x			B			
L. Osage R.	C	23.6	Mouth 18,37N,31W	18,37N,33W	Vernon			x	x			B			
L. Otter Cr.	C	6.2	Mouth	6,55N,11W	Monroe			x	x			B			
L. Otter Cr.	C	3.0	Mouth	4,56N,27W	Caldwell			x	x			B			
L. Paddy Cr.	C	3.5	Mouth	36,33N,11W	Texas			x	x			B			
L. Pike Cr.	C	1.6	Mouth	3,26N,2W	Carter			x	x			B			
L. Piney Cr.	P	7.2	Mouth	25,37N,9W	Phelps			x	x	x		A	x		
L. Piney Cr.	P	13.5	25,37N,9W	4,35N,8W	Phelps			x	x		x	A	x		
L. Piney Cr.	C	5.4	4,35N,8W	21,35N,8W	Phelps			x	x		x	B			
L. Piney Cr.	C	1.9	Mouth	12,33N,12W	Texas			x	x			B			
L. Platte R.	P	13.3	Mouth	Smithville Dam	Platte	Clay		x	x			B	x		
L. Platte R.	C	24.3	Mouth	28,57N,31W	Clinton			x	x			[B]	x		
L. Pomme de Terre R.	C	5.0	15,38N,23W	3,37N,23W	Benton	Hickory		x	x	x		A	x		
L. Pomme de Terre R.	C	6.0	Mouth	25,31N,21W	Polk	Greene		x	x			B			
L. Pomme de Terre R.	P	15.8	Mouth	15,38N,23W	Benton	Hickory		x	x			A	x		
L. Profits Cr.	P	1.7	Mouth	30,42N,11W	Osage			x	x			B			
L. Profits Cr.	C	0.5	30,42N,11W	30,42N,11W	Osage			x	x			B			
L. Ramsey Cr.	C	1.0	Mouth	16,52N,1E	Pike			x	x			B			
L. Richland Cr.	C	5.5	Mouth	12,44N,18W	Morgan			x	x			A	x		
L. Rock Cr.	C	2.3	Mouth	8,32N,5E	Madison			x	x			B			
L. Rocky Cr.	P	0.7	Mouth	12,28N,3W	Shannon			x	x			B			
L. Rocky Cr.	C	0.5	12,28N,3W	1,28N,3W	Shannon			x	x			B			
L. Sac R.	P	37.0	Mouth	McDaniel Lk. Dam	Polk	Greene		x	x	x		A	x		
L. Sac R.	P	1.3	Mouth	17,30N,21W	Greene			x	x			B			

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L. Sac R.	C	2.2	17,30N,21W	Fellows Lake Dam	Greene			x	x			B			
L. Sac R.	C	2.3	Mouth	21,30N,20W	Greene			x	x			B	x		
L. Saline Cr.	P	5.4	Mouth	29,41N,14W	Miller			x	x			B			
L. Saline Cr.	P	10.3	Mouth	24,36N,8E	Ste. Genevieve			x	x			B			
L. Sandy Cr.	C	6.0	Mouth	9,51N,1W	Lincoln			x	x			B			
L. Shaver Cr.	C	4.5	Mouth	04,45N,20W	Pettis			x	x			B	x		
L. Shawnee Cr.	P	2.0	Mouth	29,29N,3W	Shannon			x	x			B			
L. Shawnee Cr.	C	2.0	29,29N,3W	4,28N,3W	Shannon			x	x			B			
L. Shoal Cr.	P	1.9	Mouth	13,36N,2W	Crawford			x	x			A			
L. Shoal Cr.	C	1.7	13,36N,2W	24,36N,2W	Crawford			x	x			B			
L. Shoal Cr.	C	3.3	Mouth	24,51N,32W	Clay			x	x			B			
L. Shoal Cr.	C	8.7	Mouth	4,66N,16W	Putnam			x	x			B			
L. Sinking Cr.	P	4.0	Mouth	26,32N,3W	Shannon	Dent		x	x			B			
L. Sinking Cr.	C	1.0	26,32N,3W	23,32N,3W	Dent			x	x			B			
L. Sni-a-bar Cr.	P	6.7	Mouth	30,50N,27W	Lafayette			x	x			B			
L. Sni-a-bar Cr.	C	7.5	30,50N,27W	16,49N,27W	Lafayette			x	x			B			
L. Splice Cr.	P	1.7	Mouth	16,47N,14W	Moniteau			x	x			B			
L. Splice Cr.	C	2.3	16,47N,14W	20,47N,14W	Moniteau			x	x			B			
L. St. Francis R.	P	14.3	L.G 3086,33N,7E	L.G,35N,7E	Madison	St. Francois		x	x	x		A	x	x	
L. St. Francis R.	P	[32.4/17.9	Mouth	[32,35N,07E]	Madison	St. Francois		x	x	x		A	x	x	
L. St. Francis R.	C	0.8	32,35N,7E	6,33N,7E	Madison	St. Francois		x	x			B			
L. Sugar Cr.	C	4.0	Mouth	10,49N,1E	Lincoln			x	x			B			
L. Sugar Cr.	P	13.2	Mouth	State Line	McDonald		x	x	x	x		A	x		
L. Tabo Cr.	C	9.2	Mouth	3,50N,25W	Lafayette			x	x			B			
L. Tarkio Cr.	P	17.7	Mouth	19,63N,39W	Holt			x	x			B	x		
L. Tarkio Cr.	C	15.4	30,63N,39W	13,65N,39W	Atchison			x	x			B			
L. Tarkio Ditch	P	6.6	Mouth	36,61N,39W	Holt			x	x			B			
L. Taum Sauk Cr.	C	2.3	Mouth	25,33N,2E	Reynolds			x	x			B			
L. Tavern Cr.	C	4.0	Mouth	33,42N,13W	Miller	Cole		x	x	x		A			
L. Tavern Cr.	P	1.5	[33,39N,12W]	34,39N,12W	Miller			x	x			B			
L. Tavern Cr.	C	1.5	Mouth	34,39N,12W	Miller			x	x			B			
L. Tavern Cr.	P	11.2	Mouth	5,39N,11W	Miller	Maries		x	x			A			
L. Tavern Cr.	C	1.0	Mouth	11,44N,2E	Franklin			x	x			B			
L. Tavern Cr.	C	2.7	05,39N,11W	07,39N,11W	Maries			x	x			B			
L. Tavern Cr.	C	1.0	Mouth	36,46N,7W	Callaway			x	x			B			
L. Tebo Cr.	C	6.0	Mouth	20,42N,22W	Benton			x	x			[B]	x		
L. Third Cr.	C	4.6	Mouth	23,42N,7W	Osage			x	x			B			
[L. Third Fk. Plane R.]	C	26.0	Mouth	27,60N,32W	DeKalb			x	x			B			
L. Third Fk.															
L. Turkey Cr.	C	2.3	Mouth	36,40N,22W	Benton			x	x			B			
L. Walnut Cr.	C	2.3	[18,60N,16W]	14,60N,17W	Macon			x	x			B			
L. Walnut Cr.	C	2.8	Mouth	26,47N,24W	Johnson			x	x			B			
L. Weaubleau Cr.	P	5.9	Mouth	09,36N,23W	St. Clair	Hickory		x	x	x		B	x		
L. Weaubleau Cr.	C	3.3	9,36N,23W	12,36N,23W	St. Clair	Hickory		x	x			A			
L. Whitewater Cr.	P	[24.2/23.0	Mouth	[16,33N,9E]	Cape Girardeau	Bollinger		x	x			A			

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WATER BODY	CLASS	MILES	FROM	TO	COUNTY	COUNTY 2	IRR	LWW	AQL	CLF	CDF	WBC	SCR	DWS	IND
[L. Whitewater Cr.] Trib. to L. Whitewater Cr.	C	0.5	Mouth	21,33N,9E 8,33N,9E	Bollinger			x	x				B		
L. Wilson Cr.	P	2.9	Mouth	25,32N,21W	Polk			x	x				B		
L. Wilson Cr.	C	2.3	25,32N,21W	32,32N,20W	Dallas			x	x				B		
L. Wyaconda R.	P	7.4	Mouth	34,64N,8W	Clark			x	x				B		
L. Wyaconda R.	C	7.5	34,64N,8W	25,64N,9W	Clark			x	x				B		
La Barque Cr.	P	4.5	Mouth	32,43N,3E	Jefferson			x	x				B		
Labadie Cr.	P	5.0	Mouth	31,44N,2E	Franklin			x	x				B		
Ladies Br.	C	7.8	Mouth	24,37N,30W	Vernon			x	x				B		
Lake Cr.	C	10.2	12,44N,20W	17,43N,20W	Pettis	Benton		x	x	x			B		
Lake Cr.	C	5.7	Mouth	20,54N,19W	Chariton			x	x				B		
Lake Cr.	C	3.3	Mouth	29,58N,25W	Livingston			x	x				B		
Lake Cr.	P	5.4	Mouth	12,44N,20W	Pettis			x	x	x			B		
Lake Cr.	C	6.6	Mouth	34,58N,25W	Livingston			x	x				B		
Lake Ditch	C	[1.8]/2.2	Mouth	01,42N,09W	Osage			x	x				B		
Lake Slough	C	9.3	3,23N,7E	[31,25N,8E] 7,24N,8E	Butler			x	x				B		
Lamine R.	P	64.0	Mouth	13,45N,19W	Cooper	Morgan		x	x	x			A	x	
Landing Cr.	C	1.0	Mouth	16,42N,12W	Cole			x	x				B		
Landon Br.	C	3.0	Mouth	5,34N,31W	Vernon			x	x				B		
Lanes Fl.	C	[2.8]/12.4	Mouth	32,39N,7W	[Alaries] Phelps	Maries		x	x				B		
Langehammer Cr.	C	1.5	Mouth	30,43N,4W	Gasconade			x	x				B		
Larry Cr.	C	1.2	Mouth	2,59N,28W	Daviess			x	x				B		
Lateral #2	C	2.4	Mouth	8,18N,12E	Pemiscot			x	x				B		
Lateral #2 Main Ditch	P	11.5	[24,23N,10E] 14,23N,10E	25,25N,10E	Stoddard			x	x				B		
Lateral #2 Main Ditch	C	4.1	25,25N,10E	6,25N,11E	Stoddard			x	x				B		
Lateral #27	P	6.0	29,16N,9E	30,16N,10E	Dunklin			x	x				B		
Lateral #27	C	3.3	Mouth	32,20N,13E	Pemiscot			x	x				B		
Lateral #4	C	3.2	Mouth	21,27N,14E	Scott		x	x	x				B	x	
Lateral Ditch	C	2.0	Mouth	32,22N,8E	Butler			x	x				B		
Lateral Ditch	C	5.8	Mouth	3,22N,7E	Butler			x	x				B		
Lateral Ditch #1	C	4.0	Mouth	19,23N,10E	Dunklin			x	x				B		
Lateral Ditch #2	C	2.4	Mouth	9,22N,10E	Dunklin			x	x					x	
Lateral Ditch #37	C	4.3	Mouth	20,22N,8E	Butler			x	x				B		
Laurie Hollow	C	1.4	Mouth	18,39N,17W	Camden			x	x				[B]	x	
Lead Cr.	P	1.0	Mouth	7,49N,1W	Lincoln			x	x				B		
Lead Cr.	C	7.5	7,49N,1W	27,50N,2W	Lincoln			x	x				B		
Leatherwood Cr.	P	1.7	Mouth	9,31N,5E	Madison			x	x				B		
Leatherwood Cr.	C	2.5	9,31N,5E	6,31N,5E	Madison			x	x				B		
Lee Hollow	C	1.0	Mouth	27,26N,7W	Howell			x	x				B		
Lee Rowe Ditch	C	6.0	30,24N,16E	30,25N,16E	Mississippi			x	x				B		
[Leeper Cr.]	C	8.4	Mouth	21,58N,23W	Livingston			x	x				B		
Leeper Br.															
Lewis Slough	C	2.0	Mouth	32,67N,42W	Atchison			x	x				B		
Lick Br.	C	1.5	Mouth	2,24N,10W	Howell			x	x				B		

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Lick Br.	C	6.6	Mouth	19,43N,29W	Cass			x	x			B			
Lick Br.	C	1.8	Mouth	27,29N,3E	Wayne			x	x			B			
Lick Cr.	C	5.5	Mouth	9,53N,7W	Ralls			x	x			B	x		
Lick Cr.	P	2.0	Mouth	2,38N,4W	Crawford			x	x			B			
Lick Cr.	C	2.5	2,38N,4W	27,39N,4W	Crawford			x	x			[B]	x		
Lick Cr.	C	1.0	Mouth	32,22N,16W	Ozark			x	x			B			
Lick Cr.	P	6.8	25,22N,13W	19,22N,13W	Ozark			x	x			B			
Lick Cr.	C	6.1	19,22N,13W	30,23N,13W	Ozark			x	x			B			
Lick Cr.	C	4.2	Mouth	6,27N,8E	Wayne			x	x			B			
Lick Cr.	P	3.4	Mouth	25,22N,13W	Ozark			x	x			A			
Lick Cr. Ditch	C	16.2	33,25N,9E	15,26N,10E	Stoddard			x	x			B	x		
Lick Fk	C	8.9	Mouth	02,50N,27W	Lafayette			x	x			B			
Lick Fk.	C	10.1	Mouth	15,51N,13W	Boone			x	x			B			
Lick Fk.	P	5.7	Mouth	30,58N,26W	Daviess			x	x			B			
Lick Fk.	C	9.8	30,58N,26W	7,57N,27W	Daviess	Caldwell		x	x			B			
Lick Fk.	C	1.9	Mouth	2,50N,15W	Howard			x	x			B			
Lick Fk.	C	0.5	Mouth	20,44N,16W	Moniteau			x	x			B			
Lick Log Cr.	P	1.6	Mouth	32,29N,8E	Bollinger			x	x			B			
Lick Log Cr.	C	1.2	32,29N,8E	31,29N,8E	Bollinger			x	x			B			
Ligett Cr.	C	1.0	Mouth	9,26N,5E	Butler			x	x			B			
Limestone Cr.	P	8.4	Mouth	24,30N,27W	Dade			x	x	x		A			
Lincoln Cr.	C	7.4	Mouth	14,60N,36W	Andrew			x	x			B			
Lindley Cr.	P	24.1	Mouth	20,34N,20W	Hickory	Dallas		x	x			B			
Lindley Cr.	C	2.4	20,34N,20W	32,34N,20W	Dallas			x	x				x		
Line Cr.	C	7.0	Mouth	Lake Waukamis	Platte			x	x			B			
Liner Cr.	C	1.4	Mouth	9,21N,12W	Ozark			x	x			B			
Linn Cr.	C	2.3	Mouth	31,66N,8W	Clark			x	x			[B]	x		
Linn Cr.	C	6.0	Mouth	7,43N,8W	Osage			x	x			B			
Little Cr.	C	1.2	Mouth	25,51N,12W	Boone			x	x			B			
Little Cr.	C	[1.5/4.0]	Mouth	[3,40N,5E]	Jefferson			x	x			[B]	x		
Little Cr.	C	5.0	Mouth	5,40N,5E	Ozark			x	x			B	x		
Little Cr.	C	2.5	Mouth	17,24N,15W	Ozark			x	x			B			
Little Cr.	C	8.0	Mouth	1,25N,8W	Howell			x	x			B			
Little Cr.	C	4.0	Mouth	26,32N,4W	Shannon	Dent		x	x			B			
Little Cr.	C	2.7	Mouth	19,34N,1W	Iron			x	x			B			
Little Cr.	C	1.0	Mouth	12,32N,3E	Iron			x	x			B			
Little Cr.	P	3.1	Mouth	35,28N,6E	Wayne			x	x			B			
Little Cr.	C	2.7	Mouth	3,42N,3W	Franklin			x	x			[B]	x		
Little Cr.	C	11.3	Mouth	[31,65N,28W]	Harrison			x	x			B			
Little Cr.	C	3.5	Mouth	30,65N,28W	Johnson			x	x			B			
Little Cr.	P	2.7	Mouth	11,46N,28W	Wayne			x	x			B			
Little R.	P	8.0	Mouth	State Line	Mercer			x	x			B			
Littleby Cr.	C	16.0	Mouth	24,51N,8W	Audrain			x	x			B	x		
Locust Cr.	P	91.7	Mouth	State Line	Chariton	Putnam		x	x			B	x	x	
Log Cr.	C	8.8	Mouth	6,55N,28W	Caldwell			x	x			B	x		
Logan Cr.	P	7.2	Mouth	36,23N,3E	Ripley			x	x			B			

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Logan Cr.	C	7.5	36,23N,3E	9,23N,3E	Ripley			x	x			B			
Logan Cr.	P	36.0	27,29N,2E	26,31N,2W	Reynolds			x	x			A	x		
Logan Cr.	C	5.8	Mouth	30,46N,7W	Callaway			x	x			[B]	x		
Logan Cr.	C	3.4	Mouth	19,44N,13W	Cole			x	x			B	x		
Long Br.	C	[29.0]/44.6	[7,53N,8W]	7,52N,11W	Monroe	Audrain		x	x			B	x		
			Mouth												
Long Br.	C	1.5	Mouth	25,44N,2W	Franklin			x	x			B	x		
Long Br.	P	5.5	Mouth	06,45N,23W	Pettis	Johnson		x	x			B			
Long Br.	C	3.0	Mouth	29,66N,38W	Atchison			x	x			B			
Long Br.	C	3.0	Mouth	28,37N,19W	Camden			x	x			B			
Long Br.	P	6.3	Mouth	6,62N,34W	Nodaway			x	x			B			
Long Br.	C	15.0	6,62N,34W	8,64N,34W	Nodaway			x	x			B			
Long Br.	C	1.5	Mouth	27,45N,25W	Johnson			x	x			B			
Long Br.	C	2.1	Mouth	24,40N,11W	Maries			x	x			B			
Long Br.	C	5.7	Mouth	19,62N,31W	Gentry			x	x			B			
Long Br.	C	14.5	Mouth	11,59N,20W	Linn			x	x			B		x	
Long Br.	C	8.8	Mouth	18,55N,18W	Chariton			x	x			B			
Long Br.	C	6.0	06,45N,23W	09,45N,24W	Pettis	Johnson		x	x			B	x		
Long Branch Cr.	C	14.8	18,58N,14W	19,60N,14W	Macon			x	x			B	x		
Long Cr.	C	2.3	Mouth	16,40N,08W	Maries			x	x			B			
Long Cr.	C	3.3	Mouth	4,55N,28W	Caldwell			x	x			B			
Long Cr.	C	5.0	Mouth	26,54N,18W	Chariton			x	x			B			
Long Gravel Br.	P	1.0	Mouth	5,33N,5E	Madison			x	x			B			
Long Grove Br.	C	3.2	31,48N,20W	07,47N,20W	Pettis			x	x			B			
Long Grove Br.	P	0.9	Mouth	31,48N,20W	Pettis			x	x			B			
Long Run	C	1.9	Mouth	27,23N,16W	Ozark			x	x			B			
Longan Br.	C	2.3	26,41N,16W	14,41N,16W	Miller			x	x			B			
Longs Cr.	C	1.0	Mouth	[Sur 768,33N,9E]	Bollinger			x	x			B			
				LG 768,33N,9E											
Loose Cr.	C	8.5	16,44N,9W	10,43N,9W	Osage			x	x			B	x		
Loose Cr.	P	9.5	Mouth	16,44N,9W	Osage			x	x			B			
Lost Camp Cr.	C	5.3	Mouth	20,26N,8W	Howell			x	x			B			
Lost Cr.	P	6.4	Mouth	15,46N,3W	Warren			x	x	x		B			
Lost Cr.	C	3.8	15,46N,3W	2,46N,3W	Warren			x	x			B	x		
Lost Cr.	P	8.3	Mouth	19,37N,1E	Crawford	Washington		x	x			B			
Lost Cr.	C	3.0	19,37N,1E	29,37N,1E	Washington			x	x			B			
Lost Cr.	P	1.0	Mouth	5,35N,3E	Washington			x	x			B			
Lost Cr.	C	[2.5]/5.5	5,35N,3E	[9,35N,3E]	Washington			x	x			B			
				14,35N,3E											
Lost Cr.	P	8.5	State Line	14,25N,33W	Newton			x	x	x		A	x		
Lost Cr.	C	25.2	Mouth	King Lake	DeKalb			x	x			B			
Lost Cr.	C	5.5	[15,64N,16W]	5,64N,15W	Schuyler			x	x			B			
			Mouth												
Lost Cr.	C	1.8	Mouth	36,61N,32W	DeKalb	Gentry		x	x			B			
Lottie Hollow	C	1.0	Mouth	35,24N,12W	Ozark			x	x			B			
Lotts Cr.	C	9.7	Mouth	8,66N,29W	Worth	Harrison		x	x			B			
Loutre Cr.	C	4.5	Mouth	30,46N,4W	Warren			x	x			B			
Loutre R.	P	39.4	Mouth	5,48N,6W	Montgomery			x	x			B			

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Loutre R.	C	15.1	5,48N,6W	36,50N,8W	Montgomery	Audrain		x	x			B			
Loutre Slough	P1	5.5	Mouth	19,46N,4W	Warren			x	x			B			
Lovejoy Cr.	P	1.0	Mouth	Sur 2246,33N,14E	Cape Girardeau			x	x			B			
Lovejoy Cr.	C	1.5	Sur 2246,33N,14E	24,33N,13E	Cape Girardeau			x	x			B			
Lower Peavine Cr.	C	1.0	Mouth	11,40N,7W	Maries			x	x			B			
Lower Rock Cr.	C	3.5	Mouth	32,33N,5E	Madison			x	x			B			
Ludecker Hollow	C	2.0	Mouth	4,23N,14W	Ozark			x	x			B			
[Lumpkin Cr.]	C	0.5	Mouth	29,47N,32W	Jackson			x	x			B			
Lumpkins Fk.															
Luther Br.	C	[0.6]/1.9	Mouth	[32,38N,06W]	Phelps			x	x			B			
				33,38N,6W											
Luytown Cr.	C	2.0	Mouth	16,44N,8W	Osage			x	x			B			
Luzon Br.	C	1.0	13,44N,10W	24,44N,10W	Osage			x	x			B			
Luzon Br.	P	0.7	Mouth	13,44N,10W	Osage			x	x			B			
Lyman Cr.	C	1.0	Mouth	30,40N,3W	Crawford			x	x		x	A			
M. Fk. Fourche a Renault Cr.	C	1.8	Mouth	25,37N,1E	Washington			x	x			B			
M. Fk. L. Chariton R.	C	17.6	Mouth	3,58N,15W	Macon			x	x			B	x		
M. Fk. Little Chariton R.	P	31.5	Mouth	24,55N,16W	Chariton	Randolph		x	x			B		x	
M. Fk. Salt R.	P	[58.1]/57.3	Mouth	16,56N,13W	Monroe	Macon	x	x	x			B	x	x	
M. Fk. Salt R.	C	25.4	16,56N,13W	23,59N,14W	Macon			x	x			B	x		
Mace Cr.	C	5.8	Mouth	25,59N,36W	Andrew			x	x			B			
Macks Cr.	P	8.7	Mouth	12,37,19W	Camden			x	x			B			
Macks Cr.	C	2.8	12,37N,19W	23,37N,19W	Camden			x	x			[B]	x		
Madden Cr.	C	4.5	Mouth	29,36N,8E	Ste. Genevieve			x	x			B			
Maddin Cr.	C	1.9	Mouth	[35,39N,3E]	Washington			x	x			B			
				LG 1875,39N,3E											
Maddox Br.	C	2.8	35,48N,9W	23,48N,9W	Callaway			x	x			B	x		
Mag Cr.	C	0.1	Mouth	26,40N,10W	Maries			x	x			B			
Mahans Cr.	P	4.3	Mouth	9,28N,4W	Shannon			x	x	x		B			
Mahans Cr.	C	4.4	9,28N,4W	28,28N,04W	Shannon			x	x			B			
Main Ditch	C	13.0	18,22N,6E	15,24N,6E	Butler		x	x	x			B			
Main Ditch	P	11.9	14,16N,10E	30,18N,11E	Pemiscot			x	x			B	x		
Main Ditch	P	23.2	8,19N,10E	19,23N,10E	Dunklin			x	x			B			
Main Ditch	C	6.0	19,23N,10E	20,24N,10E	Dunklin	Stoddard		x	x			[B]	x		
Main Ditch #36	C	1.8	21,19N,10E	9,19N,10E	Dunklin			x	x			B			
Main Ditch #8	P	18.3	27,18N,10E	3,19N,12E	Pemiscot			x	x			B			
Main Ditch #8	C	11.5	3,19N,12E	18,20N,14E	Pemiscot			x	x				x		
[Malarini Cr.]	C	[1.5]/1.2	Mouth	[19,56N,3W]	Ralls			x	x			B			
Hascall Cr.				LG 1809,56N,3W											
Maline Cr.	C	0.6	[Sur 3125,46N,7E]	9,46N,7E	St. Louis City	St. Louis		x	x			B	x		
			LG 3,46N,7E												
Maline Cr.	C	0.5	Mouth	[Sur 3125,46N,7E]	St. Louis City			x	x				x		
				LG 3,46N7E											
Malone Cr.	P	6.9	Mouth	34,30N,10E	Bollinger			x	x			B			
Malone Cr.	C	2.3	34,30N,10E	28,30N,10E	Bollinger			x	x			B			
Mammoth Cr.	P	0.7	Mouth	11,39N,03E	Jefferson			x	x			B			
Manacle Cr.	C	2.4	Mouth	35,49N,11W	Callaway			x	x			[B]	x		

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Maple Slough	C	18.2	Mouth	11,26N,15E	New Madrid	Mississippi		x	x			B			
Marais des Cygnes R.	P	[32.0]/49.0	[19,38N,29W] Mouth	State Line	Bates		x	x	x			A	x	x	
Marble Cr.	P	14.7	Mouth	28,33N,4E	Madison	Iron		x	x	x		B	x		
Marble Cr.	C	[1.0]/2.0	28,33N,4E	20,33N,4E	Iron			x	x			B			
Maries R.	C	18.1	24,40N,10W	13,38N,11W	Maries			x	x			B			
Maries R.	P	44.0	Mouth	24,40N,10W	Osage	Maries		x	x	x		A	x		
Marlin Cr.	C	3.4	34,48N,20W	04,47N,20W	Pettis			x	x			B			
Marlin Cr.	P	3.7	Mouth	34,48N,20W	Pettis			x	x			B			
Marlowe Cr.	P	6.7	Mouth	30,66N,31W	Worth			x	x			B			
Marlowe Cr.	C	1.0	30,66N,31W	19,66N,31W	Worth			x	x			B			
Marnaton R.	P	35.7	11,37N,31W	State Line	Vernon		x	x	x			B			
Marney Br.	C	5.4	Mouth	3,43N,15W	Moniteau			x	x			B			
Marrowbone Cr.	P	11.5	Mouth	36,58N,28W	Daviess			x	x			B			
Marrowbone Cr.	C	13.9	36,58N,28W	15,58N,29W	Daviess			x	x			B			
Marsh Cr.	P	2.3	Mouth	34,32N,5E	Madison			x	x			B			
Marsh Cr.	C	0.6	34,32N,5E	33,32N,5E	Madison			x	x			B			
Marshall's Cr.	C	15.4	Mouth	33,40N,27W	Henry			x	x			B			
Martin Br.	C	0.5	Mouth	2,40N,04W	Franklin			x	x			B			
Martin Cr.	C	6.9	Mouth	27,64N,25W	Harrison	Mercer		x	x			B			
Martin Hollow	C	1.0	Mouth	1,32N,7E	Madison			x	x			B			
Mary's Cr	P	1.0	Mouth	[03,39N,01W] 3,39N,1W	Washington			x	x			B			
Marys Hollow	C	4.6	Mouth	5,24N,11W	Ozark			x	x			B			
Mash Cr.	P	0.5	Mouth	12,30N,4W	Shannon			x	x			B			
Mash Cr.	C	2.0	[12,30N,4W] 1,30N,4W	[35,31N,4W] 36,31N,4W	Shannon			x	x			B			
Mash Hollow	C	1.0	Mouth	33,24N,24W	Stone			x	x			B			
Mason Springs Valley	P	1.0	State Line	21,24N,34W	Newton			x	x			B			
Massey Cr.	C	7.0	2,44N,33W	20,45N,33W	Cass			x	x			B			
Massie Cr.	P	4.0	Mouth	10,46N,4W	Warren			x	x			B			
Massie Cr.	C	3.5	10,46N,4W	36,47N,4W	Warren			x	x			B	x		
Mattese Cr.	P	[1.1]/4.8	Mouth	[15,43N,6E] 33,44N,6E	St. Louis			x	x			B	x		
Mattese Cr.	C	3.1	33,44N,6E	LG 3117,44N,6E	St. Louis			x	x			B	x		
Maupin Br.	C	1.6	Mouth	35,47N,14W	Moniteau			x	x			B			
Maupin Cr.	P	1.3	Mouth	36,41N,02E	Jefferson			x	x			B			
Max Cr.	C	3.6	Mouth	26,24N,19W	Taney			x	x			B	x		
May Br.	C	0.5	Mouth	Hwy AN	Franklin			x	x			B			
May Br.	C	3.5	Mouth	30,48N,22W	Saline	Pettis		x	x			B			
Mayfield Cr.	P	0.8	Mouth	21,32N,10E	Bollinger			x	x			B			
Mayfield Cr.	C	2.7	21,32N,10E	18,32N,10E	Bollinger			x	x			B			
Mayhan Br.	C	1.3	Mouth	18,28N,08W	Texas			x	x				x		
Maze Cr.	C	2.0	Mouth	9,32N,25W	Dade			x	x			B			
McCarty Cr.	C	13.2	Mouth	31,34N,29W	Vernon			x	x			B			
McClanahan Cr.	C	2.5	Mouth	Sur 911,36N,11E	Perry			x	x			B			
McCoy Cr.	P	1.9	Mouth	6,47N,2E	St. Charles			x	x			B			
McCoy Cr.	C	4.5	6,47N,2E	[10,47N,1E]	St. Charles			x	x			B			

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McDade Br.	P	0.7	Mouth	LG 386,47N,1E	Crawford			x	x			B			
McDade Br.	C	1.7	9,39N,5W	17,39N,5W	Crawford			x	x			B			
McElroy Cr.	C	3.0	Mouth	9,66N,41W	Atchison			x	x			B			
McGee Br.	C	3.9	Mouth	03,44N,20W	Pettis			x	x			B			
McGee Cr.	P	7.2	Mouth	20,28N,8E	Wayne			x	x			B			
McGuire Br.	C	5.4	Mouth	7,56N,32W	Clinton			x	x			B			
McKenzie Cr.	P	6.3	Mouth	23,29N,3E	Wayne			x	x			B			
McKenzie Cr.	C	4.7	23,29N,3E	34,30N,3E	Wayne			x	x			[B]			
McKenzie Cr.	C	5.5	Mouth	06,37N,29W	Vernon			x	x			B			
McKill Cr.	P	2.7	Mouth	34,34N,33W	Vernon			x	x			B			
McKill Cr.	C	2.2	34,34N,33W	35,34N,33W	Vernon			x	x			B			
McKinney Cr.	C	0.7	Mouth	23,48N,9W	Callaway			x	x			B			
McLean Cr.	C	6.6	Mouth	16,49N,2E	Lincoln			x	x			B			
McMullen Br.	C	1.2	Mouth	18,39N,5E	Jefferson			x	x			[B]	x		
McVey Br.	C	1.5	Mouth	[3,21N,16W]	Ozark			x	x			B			
Meadows Cr.	P	1.4	Mouth	4,21N,16W											
Meadows Cr.	C	2.0	10,45N,13W	16,45N,13W	Cole			x	x			B			
Meddleberger Br.	C	1.1	Mouth	34,40N,11W	Maries			x	x			B			
Medicine Cr.	P	31.3	Mouth	9,61N,22W	Livingston	Grundy		x	x			B			
Medicine Cr.	P	43.8	9,61N,22W	State Line	Grundy	Putnam		x	x			B			
Medlen Cr.	C	1.0	Mouth	6,43N,15W	Moniteau			x	x			B			
Melton Cr.	C	2.8	Mouth	21,36N,29W	Vernon			x	x			B			
Menokenut Slough	C	10.4	Mouth	33,24N,8E	Butler			x	x						
Meramec R.	P	[76.0]/76.4	Big R.	[Meramec State Pk.]	Jefferson	Franklin		x	x	x		A	x	x	x
Meramec R.	P	51.3	13,40N,2W	22,38N,5W	Franklin	Crawford		x	x	x		A	x		x
Meramec R.	P	[10.0]/11.6	22,38N,5W	6,37N,5W	Crawford			x	x	x	x	A	x		
Meramec R.	P	38.9	7,37N,5W	19,34N,4W	Crawford	Dent		x	x	x		A	x		
Meramec R.	C	4.0	19,34N,4W	4,33N,4W	Dent			x	x	x		B			
Meramec R.	P	22.8	Mouth	[18,44N,5E]	St. Louis			x	x			A	x	x	x
Meramec R.	P	15.7	[18,44N,5E]	LG 1983,44N,5E Big R.	St. Louis	Jefferson		x	x	x		A	x	x	x
Merrills Br.	C	3.2	Mouth	19,58N,8W	Marion			x	x			B			
Miami Cr.	P	[19.6]/20.8	Mouth	4,40N,32W	Bates			x	x			B			
Miami Cr.	C	[15.6]/14.8	[10,40N,32W]	4,41N,33W	Bates			x	x			B			
Miami Cr.	P	2.3	22,39N,31W	8,39N,31W	Bates			x	x			B	x		
Mid. Fk. Shoal Cr.	C	1.3	Mouth	35,36N,2W	Crawford			x	x			B			
Mid. Richland Cr.	C	9.4	Mouth	6,42N,18W	Morgan			x	x			A	x		
Middle Big Cr.	C	9.4	Mouth	Lake Winnebago Dam	Cass			x	x			B			
Middle Br. Squaw Cr.	C	3.0	Mouth	5,62N,38W	Holt			x	x			B			
Middle Brushy Cr.	C	7.0	Mouth	32,27N,3E	Wayne	Carter		x	x			A			
Middle Cr.	C	6.5	Mouth	14,62N,25W	Grundy			x	x			B			
Middle Fabius R.	P	75.7	Mouth	22,64N,12W	Lewis	Scotland		x	x			A	x	x	

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Middle Fk.	P	7.0	Mouth	28,25N,6W	Oregon			x	x			A	x		
Middle Fk.	C	12.0	28,25N,6W	4,24N,7W	Oregon	Howell		x	x			B	x		
Middle Fk. Big Cr.	P	2.0	Mouth	19,31N,7E	Madison			x	x			B			
Middle Fk. Big Cr.	C	1.0	19,31N,7E	18,31N,7E	Madison			x	x			B			
Middle Fk. Black R.	P	21.0/22.0	Mouth	24,34N,1W	Reynolds	Iron		x	x	x		A			
Middle Fk. Black R.	C	1.2	24,34N,1W	13,34N,1W	Iron			x	x	x		A			
Middle Fk. Grand R.	P	27.5	Mouth	12,66N,31W	Gentry	Worth	x	x	x			A	x		
Middle Fk. Grand R.	C	2.5	12,66N,31W	State Line	Worth			x	x			B	x		
Middle Fk. Lost Cr.	C	8.0	Mouth	27,60N,31W	DeKalb			x	x			B			
Middle Fk. Tebo Cr.	C	7.5	Mouth	6,43N,24W	Henry			x	x			B	x		
Middle Fork	C	3.2	Mouth	20,43N,03W	Franklin			x	x			B			
Middle Indian Cr.	C	2.5	Mouth	19,27N,10W	Douglas	Howell		x	x			B			
Middle Indian Cr.	C	3.5	16,24N,30W	12,24N,30W	Newton			x	x			[B]	x		
Middle Indian Cr.	P	2.2	Mouth	16,24N,30W	Newton			x	x			B			
Middle Prong Brushy Cr.	C	1.0	Mouth	29,30N,3W	Shannon			x	x			B			
Middle Prong Crooked Cr.	P	2.2	Mouth	24,35N,4W	Dent			x	x			B			
Middle Prong Crooked Cr.	C	2.0	24,35N,4W	29,35N,3W	Dent	Crawford		x	x			B			
Middle R.	P	15.0	Mouth	4,45N,9W	Callaway			x	x			B			
Middle R.	C	10.6	4,45N,9W	2,46N,10W	Callaway			x	x			B			
Middle Tarkio Cr.	C	10.0	Mouth	State Line	Atchison		x	x	x			B	x		
Middlebrook Cr.	C	1.1	Mouth	07,34N,04E	St. Francois			x	x			B			
Mikes Cr.	P	4.0	Mouth	14,22N,30W	McDonald		x	x	x			A			
Mill Br.	P	1.2	Mouth	3,38N,2E	Washington			x	x			B			
Mill Br.	C	1.0	3,38N,2E	2,38N,2E	Washington			x	x			B			
Mill Cr.	P	1.5	Mouth	30,39N,14W	Miller			x	x			B			
Mill Cr.	C	2.0	30,39N,14W	28,39N,14W	Miller			x	x			B			
Mill Cr.	P	4.8	Mouth	25,37N,15W	Camden			x	x			A	x		
Mill Cr.	P	2.0	Mouth	9,36N,18W	Dallas			x	x		x	B			
Mill Cr.	P	1.5	9,36N,18W	8,36N,18W	Dallas			x	x			B			
Mill Cr.	P	5.8	Mouth	8,37N,21W	Hickory			x	x	x		B			
Mill Cr.	P	1.3	Mouth	29,37N,9W	Phelps			x	x			A			
Mill Cr.	P	6.7	29,37N,9W	Yelton Spring	Phelps			x	x		x	A			
Mill Cr.	P	3.5	Yelton Spring	5,35N,9W	Phelps			x	x			B			
Mill Cr.	C	5.0	Mouth	Sur 1767,51N,1W	Lincoln			x	x			B	x		
Mill Cr.	C	4.3	Mouth	3,36N,8E	Ste. Genevieve			x	x			B			x
Mill Cr.	P	13.5	Mouth	18,37N,3E	St. Francois	Washington		x	x			B			
				LG 3172,37N,3E											
Mill Cr.	P	3.0	Mouth	36,36N,3E	Washington			x	x			B			
Mill Cr.	C	0.8	36,36N,3E	36,36N,3E	Washington			x	x			B			
Mill Cr.	P	10.0	Mouth	2,59N,38W	Holt			x	x			B			
Mill Cr.	P	2.7	Mouth	8,27N,1W	Carter			x	x			A			
Mill Cr.	C	2.4	8,27N,1W	1,27N,2W	Carter			x	x			B			
Mill Cr.	C	1.4	Mouth	7,25N,6E	Butler			x	x			B			
Mill Cr.	P	3.5	Mouth	33,33N,7E	Madison			x	x			B			
Mill Cr.	C	1.0	33,33N,7E	33,33N,7E	Madison			x	x			B			
Mill Cr.	C	2.0	Mouth	30,31N,5E	Wayne	Madison		x	x			B			
Mill Cr.	P	10.8	Mouth	State Line	Nodaway			x	x			B			

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Mill Cr.	P	2.5	Mouth	24,21N,33W	McDonald			x	x			A			
Mill Cr.	C	3.9	Mouth	17,46N,33W	Jackson	Cass		x	x			B	x		
Mill Cr.	C	3.2	[08,37N,21W]	15,37N,21W	Hickory			x	x	x		B			
			8,37N,21W												
Mill Cr.	P	0.4	Mouth	21,39N,8W	Maries			x	x			B			
Mill Cr.	C	1.4	21,39N,8W	22,39N,08W	Maries			x	x			B			
Mill Cr.	P	0.5	Mouth	03,37N,10W	Phelps			x	x			B			
Mill Cr.	C	1.3	Mouth	8,56N,28W	Caldwell			x	x			B			
Mill Rock Cr.	C	1.3	Mouth	9,35N,2W	Crawford			x	x			B			
Mill Spring Cr.	P	1.0	Mouth	3,40N,8W	Maries			x	x			B			
Millan Hollow	C	1.4	Mouth	1,29N,20W	Greene			x	x						
Miller Cr.	C	6.6	Mouth	3,26N,4E	Wayne			x	x			B			
Millers Cr.	C	1.9	Mouth	14,47N,11W	Callaway			x	x			B			
Milligan Cr.	C	9.0	Mouth	18,53N,12W	Monroe			x	x			B			
Mine a Breton Cr.	P	9.0	7,38N,2E	[10,37N,2E]	Washington			x	x			B			
				LG 430,37N,2E											
Mine a Breton Cr.	C	3.0	[10,37N,2E]	[23,37N,2E]	Washington			x	x			B			
			LG 430,37N,2E	LG 2148,37N,2E											
Mineral Br.	C	1.7	Mouth	17,44N,15W	Moniteau			x	x			B			
Mineral Cr.	C	4.6	Mouth	20,44N,25W	Johnson			x	x			B			
Mineral Fk.	P	16.7	Mouth	7,38N,2E	Washington			x	x	x		A			
Mineral Spring Hollow	C	0.8	Mouth	30,31N,09W	Texns			x	x			B			
Mingo Cr.	C	2.0	Mouth	5,26N,8E	Stoddard			x	x			B			
Mingo Ditch	P	16.0	Mouth	32,27N,8E	Stoddard			x	x			B			
Minnow Br.	C	1.0	Mouth	25,41N,20W	Benton			x	x			B			
Minor Cr.	C	2.0	Mouth	11,33N,3E	Iron			x	x			B			
Mission Cr.	C	2.4	[Hwy. 45]	17,54N,36W	Platte			x	x			B			
			5,7S,22E												
Mississippi R.	P	6.3	N Riverfront Park	Missouri R.	St. Louis City	St. Charles	x	x	x			B	x	x	x
Mississippi R.	P	28.3	Meramec R.	N Riverfront Park	St. Louis	St. Louis City	x	x	x				x	x	x
Mississippi R.	P	125.1	State Line	Ohio R.	Pemiscot	Mississippi	x	x	x			B	x	x	x
Mississippi R.	P	[94.4]/94.0	[Civire R.]	Lock and Dam 21	St. Charles	Marion		x	x			A	x	x	x
			Peruque Cr.												
Mississippi R.	P	[44.1]/38.8	Missouri R.	[Civire R.]	St. Charles			x	x			A	x	x	x
			Peruque Cr.												
Mississippi R.	P	44.6	Kaskaskia R.	Meramec R.	Ste. Genevieve	St. Louis	x	x	x			B	x	x	x
Mississippi R.	P	120.1	Ohio R.	Kaskaskia R.	Mississippi	Ste. Genevieve	x	x	x			B	x	x	x
Mississippi R.	P	37.5	Lock & Dam 21	Des Moines R.	Marion	Clark		x	x			A	x	x	x
Missouri R.	P	104.5	Mouth	Gasconade R.	St. Louis	Gasconade	x	x	x			B	x	x	x
Missouri R.	P	129.0	Chariton R.	Kansas R.	Chariton	Jackson	x	x	x			B	x	x	x
Missouri R.	P	135.0	Gasconade R.	Chariton R.	Gasconade	Chariton	x	x	x			B	x	x	x
Missouri R.	P	184.5	Kansas R.	State Line	Jackson	Archison	x	x	x			B	x	x	x
Mistaken Cr.	P	6.5	Mouth	20,42N,7W	Osage			x	x			B			
Mistaken Cr.	C	1.5	20,42N,7W	30,42N,7W	Osage			x	x			B			
Mocasin Cr.	C	2.6	Mouth	26,63N,33W	Gentry			x	x			B			
Modoc Cr.	C	3.3	[32,46N,5W]	25,46N,6W	Montgomery			x	x						
			Mouth												

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Monegan Cr.	P	4.8	Mouth	21,38N,27W	St. Clair			x	x			A	x		
Monegan Cr.	C	18.4	21,38N,27W	4,39N,28W	St. Clair			x	x			B	x		
Moniteau Cr.	P	25.7	Mouth	5,50N,14W	Howard			x	x			B	x		
Moniteau Cr.	C	14.4	5,50N,14W	16,52N,14W	Howard	Randolph		x	x			B	x		
Moniteau Cr.	C	16.1	16,46N,15W	21,46N,17W	Moniteau	Cooper		x	x			B	x		
Moniteau Cr.	P	19.6	Mouth	16,46N,15W	Cole	Moniteau		x	x			B	x		
Montgomery Br.	C	6.5	15,38N,23W	6,37N,22W	Hickory			x	x			B			
Mooney Br.	C	2.2	Mouth	3,33N,10W	Texas			x	x					x	
Moore Br.	C	5.7	Mouth	27,35N,31W	Vernon			x	x			B			
Moore Br.	P	3.0	Mouth	34,35N,33W	Vernon			x	x			B			
Moore Br.	C	2.3	34,35N,33W	33,35N,33W	Vernon			x	x			B			
Moreau R.	P	37.0	Mouth	1,43N,13W	Cole			x	x			A	x		
Morgan Cr.	C	1.5	Mouth	17,43N,14W	Cole			x	x			B			
Mormon Fk.	C	21.2	Mouth	19,42N,32W	Bates			x	x			B			
Morris Br.	C	1.0	Mouth	12,49N,7W	Callaway			x	x			B			
Morris Hollow	C	1.7	Mouth	17,22N,16W	Ozark			x	x			B			
Moss Br.	C	2.4	Mouth	16,66N,37W	Nodaway			x	x			B			
Moss Cr.	P	13.7	Mouth	34,52N,25W	Carroll			x	x			B			
Moss Hollow	C	1.0	Mouth	Sur 1963,42N,5E	Jefferson			x	x			B			
Mossy Cr.	C	0.2	Mouth	[07,40N,21W]	Benton			x	x			B			
				7,40N,21W											
Mound Br.	C	8.9	Mouth	13,40N,31W	Bates			x	x			B	x		
Mound Cr.	C	4.0	Mouth	7,56N,23W	Livingston			x	x			B			
Mountain Cr.	P	6.8	Mouth	23,35N,17W	Laclede			x	x			B			
Mouse Cr.	C	1.5	Mouth	22,47N,32W	Jackson			x	x			B			
Mozingo Cr.	C	5.1	Mouth	13,64N,35W	Nodaway			x	x			B	x		
Mud Cr.	C	17.5	Mouth	20,55N,13W	Monroe	Randolph		x	x			B	x		
Mud Cr.	C	4.3	Mouth	22,26N,7E	Butler			x	x			B			
Mud Cr.	C	1.3	Mouth	08,34N,04E	St. Francois			x	x			B			
Mud Cr.	P	4.5	36,56N,26W	23,55N,26W	Caldwell			x	x			B			
Mud Cr.	C	6.7	23,55N,26W	18,54N,26W	Caldwell	Ray		x	x			B			
Mud Cr.	C	1.5	Mouth	6,51N,15W	Howard			x	x			B			
Mud Cr.	C	1.5	Mouth	5,45N,13W	Cole			x	x			B			
Mud Cr. Ditch	P	3.5	28,56N,25W	36,56N,26W	Livingston	Caldwell		x	x			B			
Mud Ditch	C	9.0	Mouth	11,23N,15E	New Madrid			x	x			B			
Muddy Cr.	C	2.8	Mouth	19,38N,30W	Vernon	Bates		x	x			B			
Muddy Cr.	C	3.0	Mouth	Sur 3017,39N,7E	Jefferson			x	x			[B]	x		
Muddy Cr.	C	5.2	Mouth	11,65N,37W	Nodaway			x	x			B			
Muddy Cr.	C	6.6	31,58N,20W	05,58N,20W	Linn			x	x			B			
Muddy Cr.	C	3.7	Mouth	21,59N,26W	Daviess			x	x			B	x		
Muddy Cr.	C	9.7	Mouth	27,60N,30W	Daviess	DeKalb		x	x			B			
Muddy Cr.	P	42.0	Mouth	22,66N,23W	Grundy	Mercer		x	x			B	x		
Muddy Cr.	C	5.7	Mouth	31,58N,20W	Linn			x	x			B			
Muddy Cr.	C	33.1	Mouth	14,61N,22W	Livingston	Sullivan		x	x			B			
Muddy Cr.	P	62.2	Mouth	17,45N,23W	Pettis			x	x			B			
Muddy Cr.	C	10.4	17,45N,23W	34,45N,24W	Pettis	Johnson		x	x			B	x		
Muddy Cr.	C	9.0	Mouth	22,52N,21W	Saline			x	x			B			
Muddy Cr.	C	2.6	Mouth	5,44N,31W	Cass			x	x			B			

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Muddy Fk.	C	8.4	Mouth	35,54N,31W	Clay			x	x			B	x		
Muddy Shawnee Cr.	P	2.5	8,33N,13E	19,33N,13E	Cape Girardeau			x	x			B			
Muddy Shawnee Cr.	C	2.6	19,33N,13E	31,33N,13E	Cape Girardeau			x	x			B	x		
Mulberry Cr.	C	10.3	Mouth	33,41N,33W	Bates			x	x			B	x		
Mulberry Cr.	C	5.4	Mouth	04,34N,29W	Vernon			x	x			B			
Mulkey Cr.	C	5.0	Mouth	28,48N,25W	Johnson			x	x			B			
Muncas Cr.	P	4.0	Mouth	4,53N,16W	Chariton			x	x			B			
Muncas Cr.	C	8.8	4,53N,16W	6,54N,15W	Randolph			x	x			B			
Murphy Cr.	C	4.2	Mouth	8,36N,14W	Camden			x	x			B			
Musco Cr.	P	1.5	Mouth	26,34N,6E	Madison			x	x			B			
Musco Cr.	C	1.2	26,34N,6E	22,34N,6E	Madison			x	x			[B]	x		
Mussel Fk.	C	29.0	18,58N,17W	2,62N,18W	Macon	Sullivan		x	x			B		x	
[Mussel Fork Cr.]	P	58.0	Mouth	18,58N,17W	Chariton	Macon		x	x			B			
Mussel Fk.															
Mutton Hollow	P	2.5	Mouth	13,31N,20W	Greene			x	x			B			
Myatt Cr.	C	12.0	State Line	5,22N,7W	Howell			x	x			B	x		
Myers Br.	P	2.5	Mouth	14,60N,10W	Knox			x	x			B			
N. Ashley Cr.	P	0.7	Mouth	34,32N,7W	Dent			x	x			B			
N. Ashley Cr.	C	9.9	Mouth	34,32N,8W	Dent	Texas		x	x			B			
N. Blackbird Cr.	C	18.1	Mouth	19,66N,18W	Putnam			x	x			B	x		
N. Bridges Cr.	C	4.6	[17,22N,11W]	2,22N,11W	Ozark			x	x			B			
			Mouth												
N. Cobb Cr.	P	6.7	Mouth	2,33N,15W	Laclede			x	x			B			
N. Deepwater Cr.	C	5.4	Mouth	35,41N,29W	Henry	Bates		x	x			B			
N. Dry Sac R.	P	5.1	Mouth	22,31N,22W	Polk	Greene		x	x			B			
N. Dry Sac R.	C	4.8	9,31N,22W	19,31N,21W	Greene			x	x			B			
N. Elkhorn Cr.	P	4.4	Mouth	14,23N,31W	McDonald			x	x			B			
N. Fabius R.	P	92.0	Mouth	26,67N,14W	Marion	Schuyler	x	x	x			B	x	x	
N. Fabius R.	C	1.0	26,67N,14W	State Line	Schuyler			x	x			B			
N. Fk. Batts Cr.	C	1.0	Mouth	18,52N,16W	Howard			x	x			B			
N. Fk. Beaver Cr.	C	[2.6]/2.0	Mouth	[33,30N,12W]	Wright			x	x			B			
				27,30N,12W											
N. Fk. Blackwater R.	C	12.8	[12,46N,27W]	12,47N,28W	Johnson			x	x			B	x		
			Mouth												
N. Fk. Bratten Spring Cr.	C	1.6	Mouth	13,22N,14W	Ozark			x	x			B			
N. Fk. Buffalo Cr.	P	2.6	[20,24N,1E]	18,24N,1E	Ripley			x	x			B			
			Mouth												
N. Fk. Buffalo Cr.	C	5.9	18,24N,1E	21,24N,1W	Ripley			x	x			B			
N. Fk. Charrette Cr.	C	6.3	24,46N,02W	34,47N,02W	Warren			x	x			B			
N. Fk. Cuivre R.	P	25.1	Mouth	24,51N,3W	Lincoln	Pike		x	x			A	x		
N. Fk. Cuivre R.	C	10.0	24,51N,3W	28,52N,3W	Pike			x	x			B			
N. Fk. Finney Cr.	C	3.6	[17,49N,21W]	4,49N,21W	Saline			x	x			B			
			Mouth												
N. Fk. Fourche a Renault Cr.	C	2.5	23,37N,1E	30,37N,2E	Washington			x	x			B			
N. Fk. Fourche Cr.	P	3.0	Mouth	4,22N,1E	Ripley			x	x			B			
N. Fk. Fourche Cr.	C	5.5	[Hwy. 142]	19,23N,1E	Ripley			x	x			B			
			4,22N,1E												
N. Fk. Grindstone Cr.	C	1.8	Mouth	16,48N,12W	Boone			x	x			B	x		

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N. Fk. Hollow	C	1.5	Mouth	7,26N,4E	Butler			x	x			B			
N. Fk. Jones Cr.	P	0.5	Mouth	15,41N,03E	Jefferson			x	x			B			
N. Fk. M. Fabius R.	C	[28.2]/29.2	Mouth	[21,66N,14W]	Scotland	Schuyler		x	x			B			
N. Fk. N. Fabius R.	C	9.0	Mouth	2,66N,13W	Scotland			x	x			B			
N. Fk. S. Fabius R.	C	39.1	[29,62N,11W]	5,64N,14W	Knox	Schuyler		x	x			B	x		
N. Fk. Salt R.	P	[84.9]/75.5	Mouth	2,62N,14W	Monroe	Adair	x	x	x			B	x	x	
N. Fk. Salt R.	C	17.2	2,62N,14W	12,64N,15W	Adair	Schuyler		x	x			B			
N. Fk. Spring Cr.	C	2.5	[23,26N,10W]	7,26N,10W	Howell			x	x			B			
N. Fk. Spring R.	P	17.4	Mouth	6,29N,32W	Jasper			x	x			B	x		
N. Fk. Spring R.	C	55.9	[6,29N,32W]	20,30N,28W	Jasper	Dade		x	x			B	x		
N. Fk. Web Cr.	P	1.9	Mouth	31,29N,2E	Reynolds			x	x			B			
N. Fk. Web Cr.	C	3.0	31,29N,2E	34,29N,1E	Reynolds			x	x			B			
N. Flat Cr.	C	3.5	Mouth	27,44N,23W	Pettis			x	x			B			
N. Indian Cr.	P	5.2	24,24N,31W	36,25N,30W	Newton			x	x			B			
N. Linn Cr.	C	1.7	Mouth	36,66N,9W	Clark			x	x			B			
N. Moreau Cr.	P	47.9	Mouth	4,44N,16W	Cole	Moniteau		x	x			A	x		
N. Mud Cr.	C	6.2	Mouth	6,55N,26W	Caldwell			x	x			B			
N. Pr. Beaverdam Cr.	C	3.0	Mouth	19,25N,4E	Ripley			x	x			B			
N. Prong Jacks Fk.	P	6.8	29,28N,7W	11,28N,8W	Texas			x	x			B			
N. Prong Jacks Fk.	C	7.0	11,28N,8W	25,29N,9W	Texas			x	x			B			
N. Prong L. Black R.	P	3.2	[9,24N,3E]	32,25N,3E	Ripley			x	x			B			
N. Prong L. Black R.	C	12.2	32,25N,3E	35,26N,2E	Ripley	Carter		x	x			A			
N. Wyaconda R.	P	16.9	26,65N,9W	18,66N,10W	Clark	Scotland		x	x			B			
N. Wyaconda R.	C	9.2	18,66N,10W	31,67N,11W	Scotland			x	x			B			
Nance Cr.	C	0.5	Mouth	15,24N,14W	Ozark			x	x			B			
Narrows Cr.	C	2.6	Mouth	7,56N,13W	Macon			x	x			B			
Nations Cr.	P	4.5	Mouth	15,34N,9E	Perry			x	x			B			
Nations Cr.	C	2.0	15,34N,9E	8,34N,9E	Perry			x	x			[B]	x		
Natural Bridge Holl.	C	1.8	Mouth	17,22N,26W	Barry			x	x				x		
Naylor Cr.	C	1.0	Mouth	7,51N,34W	Platte			x	x			B			
Neals Cr.	C	3.2	Mouth	16,34N,1W	Iron			x	x			B	x		
New #7 Chute	C	1.6	35,23N,16E	6,22N,17E	Mississippi		x	x	x			B			
New Franklin Ditch	P	6.3	6,16N,12E	23,17N,12E	Pemiscot			x	x			B			
New Hope Cr.	C	5.5	Mouth	31,54N,30W	Clay			x	x			B			
Newtonia Br.	P	1.4	Mouth	1,25N,30W	Newton			x	x			B			
Niangun R.	P	56.0	Bennett Spr Cr.	33,32N,18W	Dallas	Webster		x	x	x		A	x		
Niangun R.	P	5.7	Mouth	19,37N,17W	Camden			x	x			A	x		
Niangun R.	C	6.8	19,37N,17W	19,37N,17W	Camden			x	x			A	x		
Niangun R.	P	5.0	Mouth	2,36N,18W	Camden			x	x			B			
Niangun R.	P	25.0	[Dallas County Line]	11,35N,18W	Dallas			x	x	x		A	x		
Niangun R.	P	6.0	11,35N,18W	Bennett Spring Cr.	Dallas			x	x	x	x	A	x		
Nichols Cr.	C	4.6	Mouth	17,60N,37W	Holt			x	x			B			

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Nishnabotna R.	P	10.2	Mouth	State Line	Atchison		x	x	x			B	x	x	
No Cr.	P	28.7	Mouth	14,62N,23W	Livingston	Grundy		x	x			B			
No. 13 Elk Chute	C	2.3	Mouth	35,19N,11E	Pemiscot			x	x			B			
No. 3 Island Chute	P	8.3	6,25N,18E	29,25N,18E	Mississippi		x	x				B			
Noblett Cr.	P	2.4	Mouth	Noblett Lake Dam	Douglas			x	x			B			
Noblett Cr.	P	7.0	24,26N,11W	9,26N,10W	Douglas	Howell		x	x			B			
Noblett Cr.	C	1.2	9,26N,10W	3,26N,10W	Howell			x	x			B			
Nodaway R.	P	59.3	Mouth	State Line	Andrew	Nodaway	x	x	x			B	x		
Noix Cr.	P	[1.9/1.6	Mouth	19,54N,1W	Pike			x	x			B			
Noix Cr.	C	[4.6/10.2	19,54N,1W	[3,53N,2W] 29,53N,2W	Pike			x	x			B	x		
Norborne Drainage Ditch	P	5.1	34,52N,25W	21,52N,26W	Carroll	Ray		x	x			B			
Norman Cr.	C	7.7	Mouth	08,36N,06W	Phelps			x	x			B			
Norris Cr.	C	4.0	Mouth	33,44N,27W	Henry			x	x			B			
North Branch Wilsons Cr.	P	3.8	29,29N,22W	16,29N,22W	Greene			x	x			B			
North Cut Ditch	P	24.8	Mouth	3,28N,14E	New Madrid	Scott	x	x	x			B	x		
North Cut Ditch	C	2.3	3,28N,14E	35,29N,14E	Scott		x	x	x			B	x		
North Fk.	C	1.5	Mouth	16,36N,2E	Washington			x	x			B			
North Fork R.	P	23.9	Mouth	[2,24N,12W] 34,25N,11W	Ozark		x	x	x		x	A	x		
North Fork R.	P	31.3	34,25N,11W	17,27N,11W	Douglas		x	x	x	x		A	x		
North Fork R.	C	8.0	17,27N,11W	23,28N,12W	Douglas	Texas		x	x			B			
North R.	C	8.7	26,60N,11W	13,60N,12W	Knox			x	x				x		
North R.	PI	4.0	Mouth	8,58N,5W	Marion			x	x			B	x		
North R.	P	49.0	8,58N,5W	33,59N,10W	Marion	Shelby		x	x			B	x		
North R.	C	12.8	33,59N,10W	26,60N,11W	Shelby	Knox		x	x			B	x		
Northeast Br.	P	1.0	Mouth	27,39N,1W	Washington			x	x			B			
Northeast Br.	C	1.3	27,39N,1W	34,39N,1W	Washington			x	x			B			
Norvey Cr.	C	9.3	Mouth	9,66N,34W	Nodaway			x	x			B			
Nulls Cr.	C	5.8	Mouth	15,50N,2W	Lincoln			x	x			B			
Off Davis Hollow	C	3.5	Mouth	29,22N,26W	Barry			x	x			A			
Old Bland Cr.	C	2.0	Mouth	8,41N,6W	Gasconade			x	x			B			
Old Ch. L. Tarkio Cr.	P	5.3	Mouth	22,61N,39W	Holt			x	x			B			
Old Ch. L. Tarkio Cr.	C	8.3	22,61N,39W	20,62N,39W	Holt			x	x			B			
Old Ch. Nishnabotna R.	P	13.7	30,64N,41W	1,65N,42W	Atchison			x	x			B			
Old Ch. Nishnabotna R.	C	3.0	1,65N,42W	25,66N,42W	Atchison			x	x			B			
Old Ch. St. Francis R.	P	[4.5/3.8	Mouth	34,22N,8E	Dunklin			x	x			B			
Old Ch. St. Francis R.	C	8.0	32,22N,8E	15,22N,8E	Dunklin			x	x			B			
Old Chan. Chariton R.	C	14.6	34,65N,16W	34,66N,16W	Putnam	Schuyler		x	x			B			
Old Chan. Chariton R.	C	2.0	Mouth	32,56N,16W	Chariton			x	x			B			
Old Chan. Chariton R.	P	14.5	Mouth	9,52N,18W	Chariton			x	x			B			
Old Chan. Chariton R.	C	11.0	9,52N,18W	29,53N,18W	Chariton			x	x			B			
Old Chan. Grand R.	C	3.1	12,58N,27W	35,59N,27W	Daviess			x	x			B			
Old Chan. Grand R.	C	2.5	Mouth	18,57N,24W	Livingston			x	x			B			
Old Chan. Grand R.	P	15.2	Mouth	[12,58N,26W] 12,58N,27W	Daviess			x	x			B			
Old Chan. Grand R.	C	1.5	20,57N,23W	29,57N,23W	Livingston			x	x			B			
Old Chan. Grand R.	C	5.3	7,56N,21W	2,56N,22W	Livingston			x	x			B			

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Old Chan. Grand R.	C	4.0	26,57N,23W	26,57N,23W	Livingston			x	x			B			
Old Chan. Hubble Cr.	C	2.9	Mouth	11,29N,12E	Scott	Cape Girardeau		x	x			B			
Old Chan. Little R.	C	15.4	33,20N,11E	3,20N,12E	Pemiscot			x	x			B	x		
Old Chan. Little R.	P	47.2	26,22N,12E	2,27N,12E	New Madrid	Scott		x	x			B			
Old Chan. Little R.	P	4.3	[11,27N,12E]	32,28N,12E	Scott			x	x			B			
			2,27N,12E												
Old Chan. Mud Cr.	P	3.0	Mouth	29,56N,25W	Livingston			x	x			B			
Old Chan. Nodaway R.	C	10.0	Mouth	35,62N,37W	Andrew	Holt		x	x			B			
Old Chan. Nodaway R.	C	1.2	Mouth	11,66N,37W	Nodaway			x	x			B			
Old Chan. Nodaway R.	C	2.0	Mouth	1,66N,37W	Nodaway			x	x			B			
Old Chan. Nodaway R.	C	1.5	Mouth	23,66N,37W	Nodaway			x	x			B			
Old Chan. Nodaway R.	C	1.0	Mouth	27,66N,37W	Nodaway			x	x			B			
Old Chan. Nodaway R.	C	2.5	4,65N,37W	34,66N,37W	Nodaway			x	x			B			
Old Chan. Nodaway R.	C	3.7	8,65N,37W	5,65N,37W	Nodaway			x	x			B			
Old Chan. Nodaway R.	C	2.5	Mouth	17,65N,37W	Nodaway			x	x			B			
Old Chan. Nodaway R.	C	2.8	Mouth	30,65N,37W	Nodaway			x	x			B			
Old Chan. Nodaway R.	C	1.0	1,59N,37W	1,59N,37W	Holt	Andrew		x	x			B			
Old Chan. Platte R.	C	3.4	Mouth	16,56N,34W	Buchanan			x	x			B			
Old Chan. Platte R.	C	2.2	Mouth	35,57N,34W	Buchanan			x	x			B			
Old Chan. Platte R.	C	4.0	21,57N,34W	4,57N,34W	Buchanan			x	x			B			
Old Chan. Platte R.	C	1.0	34,57N,34W	27,57N,34W	Buchanan			x	x			B			
Old Chan. Platte R.	C	5.0	4,57N,34W	28,58N,34W	Buchanan			x	x			B			
Old Chan. S. Grand R.	C	2.2	7,43N,31W	7,43N,31W	Cass			x	x			B			
Old Chan. Thompson R.	C	1.2	2,61N,25W	35,62N,25W	Grundy			x	x			B			
Old Chan. Thompson R.	C	2.7	32,63N,25W	29,63N,25W	Grundy			x	x			B			
Old Chan. Thompson R.	C	1.6	8,62N,25W	5,62N,25W	Grundy			x	x			B			
Old Chan. Thompson R.	C	8.4	34,62N,25W	8,62N,25W	Grundy			x	x			B			
Old Chan. Thompson R.	C	3.6	9,57N,24W	4,57N,24W	Livingston			x	x			B			
Old Chan. Wakenda Cr.	P	3.0	[6,52N,23W]	1,52N,24W	Carroll			x	x			B			
			Mouth												
Old Chan. Weldon R.	C	4.0	Mouth	20,62N,24W	Grundy			x	x			B			
Old Kings Lake Cr	P	3.2	[Sur 1724, 50N,2E]	35,51N,2E	Lincoln			x	x			B			
			Sur 1724,50N,2E												
Old Kings Lake Cr.	P1	6.2	Mouth	Sur 1724,50N,2E	Lincoln			x	x			B			
Old Kings Lake Cr.	C	7.3	35,51N,2E	3,51N,2E	Lincoln			x	x			B	x		
Old Mines Cr.	P	6.6	Mouth	[Sur 3039,38N,2E]	Washington			x	x			A			
				LG 3278,38N,2E											
Old Mines Cr.	C	1.0	Sur 3039,38N,2E	[Sur 3040,38N,2E]	Washington			x	x			B			
				LG 3278,38N,2E											
Old R. (Slough Miss.)	P	9.2	Mouth	18,37N,10E	Ste. Genevieve			x	x			B			
Old Town Br.	C	7.3	Mouth	14,36N,31W	Vernon			x	x			B			
Olive Br.	C	1.0	Mouth	17,46N,20W	Pettis			x	x			B			
Omete Cr.	P	3.5	Mouth	15,35N,12E	Perry			x	x			B			
Omete Cr.	C	1.2	15,35N,12E	22,35N,12E	Perry			x	x			B			
One Hundred and Two R.	P	79.7	Mouth	State Line	Buchanan	Nodaway	x	x	x			B	x	x	
Open Hollow	C	0.8	Mouth	16,28N,4W	Shannon			x	x			B			
Opossum Cr.	C	2.5	Mouth	36,30N,11W	Texas			x	x			B			

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Opossum Cr.	C	1.5	Mouth	31,40N,3W	Crawford			x	x			B			
Opossum Cr.	C	6.4	Mouth	28,30N,30W	Jasper			x	x			B			
Opossum Cr.	P	1.9	Mouth	12,30N,9E	Bollinger			x	x			B			
Opossum Cr.	C	2.2	12,30N,9E	11,30N,9E	Bollinger			x	x			B			
[Osage Fk.]	P	69.0	Mouth	26,30N,17W	Laclede	Webster		x	x	x		A	x		
Osage Fk. Gasconade R.															
Osage R.	P	81.9	Mouth	Bagnell Dam	Osage	Miller		x	x	x		A	x		
Osage R.	P	50.7	Mouth	33,38N,30W	St. Clair	Vernon		x	x	x		A	x		
Oter Cr.	C	37.6	Mouth	8,56N,12W	Monroe	Shelby		x	x			B			
Otter Cr.	C	2.2	Mouth	22,24N,16W	Ozark			x	x			B			
Otter Cr.	P	6.0	Mouth	18,27N,6E	Wayne			x	x			B			
Otter Cr.	C	18.0	18,27N,6E	18,28N,4E	Wayne			x	x			B			
Otter Cr.	C	2.5	Mouth	11,56N,27W	Caldwell			x	x			B			
Otter Cr.	C	3.0	Mouth	31,46N,18W	Cooper			x	x			[B]	x		
Otter Slough Ditch	P	4.0	12,23N,8E	19,24N,9E	Stoddard			x	x			B			
Oter Slough Ditch	P	7.3	Mouth	3,24N,13E	New Madrid			x	x			B			
Otter Cr.	P	6.9	Mouth	14,34N,1E	Reynolds	Iron		x	x			B			
Otter Cr.	C	1.8	14,34N,1E	12,34N,1E	Iron			x	x			B			
Owens Cr.	C	3.2	Mouth	21,43N,32W	Cass			x	x			B			
Owens Cr.	C	3.7	Mouth	12,42N,8W	Osage			x	x			B			
Owl Cr.	C	2.0	Mouth	11,36N,4E	St. Francois			x	x			B			
Owl Cr.	C	3.3	Mouth	27,49N,28W	Lafayette			x	x			[B]	x		
Owl Cr.	C	4.8	Mouth	24,54N,35W	Platte			x	x						
Owl Cr.	C	2.0	Mouth	3,47N,11W	Callaway			x	x			[B]	x		
P.D. Cr.	C	0.1	Mouth	28,40N,21W	Benton			x	x			B			
Painter Br.	C	3.2	Mouth	33,48N,20W	Pettis			x	x			B			
Palmer Cr.	P	12.2	Mouth	9,53N,19W	Chariton			x	x			B			
Palmer Cr.	C	2.8	9,53N,19W	33,54N,19W	Chariton			x	x			B			
Panther Cr.	C	8.0	Mouth	15,44N,29W	Johnson			x	x			B			
Panther Cr.	C	12.6	Mouth	14,39N,29W	Bates			x	x			B	x		
Panther Cr.	C	9.7	Mouth	13,35N,24W	St. Clair	Polk		x	x			B			
Panther Cr.	P	2.9	Mouth	13,32N,17W	Webster	Laclede		x	x			B			
Panther Cr.	C	0.5	13,32N,17W	14,32N,17W	Laclede			x	x			B			
Panther Cr.	P	3.1	Mouth	36,32N,10E	Cape Girardeau	Bollinger		x	x			B			
Panther Cr.	C	1.2	36,32N,10E	2,31N,10E	Bollinger			x	x			B			
Panther Cr.	P	9.3	Mouth	29,29N,18W	Webster			x	x			B			
Panther Cr.	C	2.3	Mouth	18,28N,11W	Texns			x	x			B			
Panther Cr.	C	4.8	Mouth	33,64N,30W	Gentry			x	x			B			
Panther Cr.	C	5.0	Mouth	28,57N,26W	Caldwell			x	x				x		
Panther Cr.	P	3.5	Mouth	14,64N,26W	Harrison			x	x			B			
Panther Cr.	C	6.8	14,64N,26W	36,65N,27W	Harrison			x	x			B			
Panther Hollow	C	1.5	Mouth	3,27N,07W	Howell			x	x			B			
Paris Br.	C	3.0	Mouth	31,50N,1W	Lincoln			x	x				x		
Parker Br.	P	3.4	Mouth	2,39N,32W	Bates			x	x			B			
Parker Br.	C	2.6	26,33N,3W	15,33N,3W	Reynolds			x	x			B			
[Parker Hollow]	P	2.2	Mouth	20,32N,6W	Dent			x	x		x	B			

Trib. to Current R.

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Parks Cr.	P	3.0	Mouth	30,32N,15W	Laclede	Wright		x	x			B			
Parks Cr.	C	2.4	30,32N,15W	6,31N,15W	Wright			x	x			B			
Parson Cr.	P	15.0	Mouth	23,58N,22W	Livingston	Linn		x	x			B	x		
Parson Cr.	C	14.6	23,58N,22W	31,60N,21W	Linn			x	x			B			
Pass Br.	C	3.2	Mouth	3,50N,23W	Saline			x	x			B			
Patterson Cr.	C	1.8	Mouth	35,33N,4E	Iron			x	x			B			
Patterson Cr.	P	3.5	State Line	11,22N,34W	McDonald		x	x	x			B			
Patton Br.	C	5.0	Mouth	26,33N,29W	Barton			x	x			B			
Pen Ridge Cr.	P	1.5	Mouth	2,29N,22W	Greene			x	x			B		x	
Peachtree Fk.	P	2.0	Mouth	5,29N,4E	Wayne			x	x			B			
Peachtree Fk.	C	3.2	5,29N,4E	36,30N,3E	Wayne			x	x			B			
Pearson Cr.	P	8.0	Mouth	5,29N,20W	Greene			x	x			A			
Peavine Cr.	C	1.7	Mouth	11,40N,7W	Maries			x	x			B			
Peavine Cr.	C	3.7	Mouth	20,48N,24W	Johnson			x	x			B			
Pecaut Hollow	C	1.5	Mouth	19,35N,10E	Perry			x	x			B			
Peckout Hollow	C	1.8	Mouth	9,25N,20W	Christian			x	x			B			
Peddler Cr.	P	1.5	Mouth	28,64N,31W	Gentry			x	x			B			
Peddler Cr.	C	3.0	28,64N,31W	16,64N,31W	Gentry			x	x			B	x		
Pedelo Cr.	P	0.5	Mouth	7,27N,19W	Christian			x	x			B			
Pedelo Cr.	C	1.0	7,27N,19W	6,27N,19W	Christian			x	x			B			
Pedlar Cr.	C	5.4	Mouth	23,61N,36W	Andrew			x	x			B			
Peers Slough	C	3.0	Mouth	27,45N,2W	Warren			x	x			B			
Peggy Br.	P	1.3	Mouth	32,43N,7W	Osage			x	x			B			
Peggy Br.	C	0.5	32,43N,7W	5,42N,7W	Osage			x	x			B			
Peno Cr.	C	14.4	Mouth	32,54N,3W	Pike			x	x	x		B	x		
Pepper Cr.	C	2.8	Mouth	33,44N,23W	Pettis			x	x			B			
Perche Cr.	C	23.7	5,49N,13W	19,52N,13W	Boone	Randolph		x	x			[B]	x		
Perche Cr.	P1	11.3	Mouth	29,48N,13W	Boone			x	x			B	x		
Perche Cr.	P	17.5	29,48N,13W	5,49N,13W	Boone			x	x			B	x		
Perkins Br.	P	1.5	Mouth	12,27N,6E	Wayne			x	x			B			
Perkins Cr.	C	3.0	36,30N,8E	24,30N,8E	Bollinger			x	x			B			
Perkins Cr.	P	8.5	Mouth	36,30N,8E	Bollinger			x	x			B			
Peruque Cr.	P1	[9.6]/9.4	Mouth	[9,47N,3E]	St. Charles			x	x			B	x		
				LG 1790,47N,3E											
Peruque Cr.	P	10.3	[9,47N,3E]	[Lake St. Louis Dam]	St. Charles			x	x			B	x		
			LG 1790,47N,3E	LG 54,47N,2E											
Peruque Cr.	P	4.0	Mouth	[25,47N,1E]	St. Charles			x	x			B	x		
				LG 3289,47N,1E											
Peruque Cr.	C	10.9	[25,47N,1E]	23,47N,1W	St. Charles	Warren		x	x			B	x		
			LG 3289,47N,1E												
Peters Br.	C	1.5	Mouth	13,29N,5E	Wayne			x	x			B			
Peters Cr.	C	3.5	Mouth	22,29N,8W	Texas			x	x			B			
Peters Cr.	C	1.0	Mouth	36,32N,6E	Madison			x	x			B			
Petite Saline Cr.	P	21.0	Mouth	24,48N,17W	Moniteau	Cooper		x	x			A	x		
Petite Saline Cr.	C	28.0	24,48N,17W	26,46N,18W	Cooper			x	x			B	x		
Pettis Cr.	C	5.3	Mouth	9,31N,30W	Barton			x	x			B			
Pickere! Cr.	P	3.3	Mouth	26,29N,24W	Greene			x	x			B			

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Pickel Cr.	C	0.5	26,29N,24W	26,29N,24W	Greene			x	x			[B]	x		
Pickle Cr.	P	7.8	Mouth	[19,36N,7E] LG 3161,36N,7E	Ste. Genevieve			x	x			B			
Pierce Cr.	P	2.4	Mouth	19,41N,2E	Franklin			x	x			B			
Pierce Cr.	C	2.8	19,41N,2E	31,41N,2E	Franklin			x	x			B			
Pierre Fleche Cr.	C	5.5	Mouth	15,50N,19W	Saline			x	x			B			
Pigeon Cr.	C	1.2	State Line	11,21N,13W	Ozark			x	x			B			
Pigeon Cr.	P	7.6	Montauk Spring	8,32N,7W	Dent			x	x			A			
Pigeon Cr.	C	7.7	8,32N,7W	34,33N,8W	Dent	Texas		x	x			B			
Pigeon Cr.	C	7.2	Mouth	15,56N,35W	Buchanan			x	x			B			
Pigeon Roost Cr.	C	0.5	Mouth	18,54N,7W	Monroe			x	x			B			
Pike Cr.	P	3.8	Mouth	34,27N,1W	Carter			x	x	x		B			
Pike Cr.	C	25.6	34,27N,1W	27,27N,3W	Carter	Shannon		x	x			[B]	x		
Pike Cr.	C	6.0	15,24N,6E	30,25N,6E	Butler		x	x	x						
Pike Cr.	C	5.0	18,22N,6E	33,23N,6E	Butler		x	x	x			B			
Pike Cr. Ditch	C	4.0	State Line	18,22N,6E	Butler		x	x	x			B			
Pike Run	P	1.8	Mouth	[32,38N,05E] 32,38N,5E	St. Francois			x	x			B			
Pike Run	C	0.9	32,38N,05E	28,38N,05E	St. Francois			x	x			B			
Pike Slough	C	6.4	Mouth	28,24N,6E	Butler			x	x				x		
Pilot Br.	C	1.0	Mouth	10,44N,16W	Moniteau			x	x			B			
Pilot Grove Cr.	C	5.4	Mouth	11,60N,27W	Daviess			x	x			B			
Pin Oak Cr.	P	1.3	Mouth	7,43N,6W	Gasconade			x	x			B			
Pin Oak Cr.	C	1.8	[17,43N,6W] 7,43N,6W	[Hwy. 50] 16,43N,6W	Gasconade			x	x			B			
Pin Oak Cr.	C	2.0	Mouth	3,44N,3W	Franklin			x	x			B			
Pin Oak Cr.	C	3.0	Mouth	03,42N,04W	Franklin			x	x			B			
[Pin Oak Cr.]	C	[1.6/1.8]	Mouth	[11,39N,07W] 11,39N,7W	Maries			x	x			B			
Pin Oak Br.															
Pin Oak Cr.	C	3.0	Mouth	3,45N,28W	Johnson			x	x			B	x		
Pine Br.	C	3.6	Mouth	01,28N,08W	Texas			x	x			B			
Pine Cr.	P	1.5	Mouth	30,23N,12W	Ozark			x	x			B			
Pine Cr.	C	8.6	30,23N,12W	2,23N,13W	Ozark			x	x			B			
Pine Cr.	P	9.5	Mouth	5,27N,9W	Texas	Howell		x	x			B			
Pine Cr.	C	1.0	5,27N,9W	6,27N,9W	Howell			x	x			B			
Pine Hollow	C	4.0	Mouth	25,28N,5W	Shannon			x	x			B			
Pine Run	C	5.1	Mouth	26,25N,24W	Stone			x	x			B			
Pine Valley Cr.	C	6.9	Mouth	13,28N,1W	Carter	Reynolds		x	x			B			
Pinery Cr.	C	0.8	Mouth	21,39N,1E	Washington			x	x			B			
Pinery Cr.	C	1.0	Mouth	36,40N,1E	Washington			x	x			B			
Piney Br.	C	1.2	Mouth	25,36N,1W	Washington			x	x			B			
Piney Cr.	C	2.8	Mouth	22,23N,25W	Stone	Bany		x	x			B			
Piney Cr.	C	10.5	Mouth	Hwy. 160	Oregon			x	x			[B]	x		
Piney Cr.	C	1.5	Mouth	7,33N,6E	Madison			x	x			B			
Piper Cr.	P	5.3	Mouth	31,34N,22W	Polk			x	x			B			
Pipes Br.	C	2.0	Mouth	16,49N,15W	Howard			x	x			B			
Pippin Br.	P	3.0	26,37N,20W	28,37N,20W	Hickory			x	x			B			
Pippin Br.	P	1.0	Mouth	26,37N,20W	Hickory			x	x			B			

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Platte R.	P	142.4	Mouth	State Line	Platte	Worth	x	x	x			B	x	x	
Plattin Cr.	P	[19.9]/18.9	Mouth	[01,38N,05E] 31,39N,6E	Jefferson	[St. Francois]		x	x			A	x		x
Plattin Cr.	C	3.5	[31,39N,06E] 31,39N,6E	[8,38N,06E] 8,38N,6W	Jefferson	St. Francois		x	x			B			
Pleasant Run Cr.	C	7.6	Mouth	28,34N,31W	Vernon			x	x			B			
Pleasant Valley Cr.	P	3.2	Mouth	14,39N,5W	Crawford			x	x			B			
Pleasant Valley Cr.	C	1.7	14,39N,5W	24,39N,5W	Crawford			x	x			B	x		
Plum Cr.	C	1.8	Mouth	2,33N,6E	Madison			x	x			B			
Pogue Cr.	C	[2.5]/2.9	Mouth	32,24N,28W	Barry			x	x			B			
Pointers Cr.	C	1.0	Mouth	31,43N,7W	Osage			x	x			B	x		
Pole Cat Slough	P	12.6	Mouth	2,18N,9E	Dunklin			x	x			B			
Pole Hollow	P	4.3	Mouth	25,42N,20W	Benton			x	x			B			
Polecat Cr.	C	4.0	Mouth	[13,34N,26W] 13,34N,27W	Cedar			x	x			[B]	x		
Polecat Cr.	C	11.1	Mouth	Hwy. 136	Harrison			x	x			B			
Polecat Cr.	C	2.9	Mouth	28,45N,31W	Cass			x	x			B			
Pomme Cr.	P	1.8	Mouth	Sur 2991,43N,06E	Jefferson			x	x			B	x		
Pomme de Terre R.	P	21.8	Mouth	Pomme de Terre Dam	Hickory			x	x	x		A	x		
Pomme de Terre R.	P	69.1	Mouth	8,30N,18W	Polk	Webster		x	x			A	x		
Pond Cr.	P	4.0	Mouth	5,28N,23W	Greene			x	x			B			
Pond Cr.	P	1.3	Mouth	35,38N,3E	Washington			x	x			B			
Pond Cr.	C	1.0	[Mouth] 35,38N,3E	3,37N,3E	Washington			x	x			B			
Pond Cr.	C	3.0	Mouth	30,30N,33W	Jasper			x	x			B			
Pond Cr.	P	4.4	Mouth	11,29N,8E	Bollinger			x	x			B			
Pond Cr.	C	2.0	11,29N,8E	3,29N,8E	Bollinger			x	x			B			
Pond Fk.	P	4.2	Mouth	23,23N,16W	Ozark			x	x			B			
Pond Fk.	C	6.3	23,23N,16W	[Taney Co. Line] 32,24N,16W	Ozark			x	x			B			
Pond Spring Br.	P	2.6	Mouth	15,30N,08W	Texas			x	x			B			
Poney Cr.	P	3.9	Mouth	13,44N,33W	Cass			x	x			B			
Poney Cr.	C	8.3	13,44N,33W	State Line	Cass			x	x			B			
Poor Br.	C	3.0	Mouth	13,48N,3W	Montgomery			x	x			B			
Possum Hollow	C	1.0	Mouth	12,38N,17W	Camden			x	x			B	x		
Possum Hollow	P	1.4	28,27N,7E	22,27N,7E	Wayne			x	x			B			
Possum Hollow	C	1.0	22,27N,7E	16,27N,7E	Wayne			x	x			B			
[Possum Trot Hollow]	P	2.0	Mouth	16,35N,2W	Crawford			x	x			B			
Possum Trot Cr.															
[Possum Trot Hollow]	C	1.0	16,35N,2W	21,35N,2W	Crawford			x	x			B			
Possum Trot Cr.															
Possum Walk Cr.	C	4.2	Mouth	[18,21N,13W] State Line	Ozark			x	x			B			
Post Oak Cr.	P	3.3	Mouth	22,46N,26W	Johnson			x	x			B	x		
[Potter Cr.]	P	4.4	Mouth	16,28N,10W	Texas			x	x			B			
Potter Cr.															
[Potter Cr.]	C	1.4	16,28N,10W	22,28N,10W	Texas			x	x			B			
Potter Cr.															
Prairie Cr.	C	1.5	Mouth	1,39N,5W	Crawford			x	x			B			

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Prairie Cr.	C	4.3	Mouth	3,27N,15W	Douglas			x	x			B			
Prairie Cr.	C	3.7	Mouth	12,52N,35W	Platte			x	x			B	x		
Prairie Cr.	C	3.5	Mouth	35,39N,22W	Benton			x	x			B			
Prairie Cr.	C	2.0	Mouth	36,39N,11W	Maries			x	x			B			
Prairie Cr.	C	4.1	Mouth	[04,32N,12W]	Texas	Laclede		x	x			B			
Prairie Fk.	P	2.9	Mouth	4,32N,12W	Montgomery			x	x			B			
Prairie Fk.	C	5.0	8,47N,6W	10,47N,7W	Montgomery	Callaway		x	x			B			
Prairie Fk.	C	0.8	Mouth	21,44N,3W	Franklin			x	x			B			
Prairie Fk.	C	3.9	Mouth	20,46N,9W	Callaway			x	x			B			
Prairie Hollow	P	6.8	Mouth	04,37N,18W	Camden			x	x			B			
Prairie Run Hollow	C	1.0	Mouth	25,25N,27W	Barry			x	x			B			
Price Br.	C	3.0	Mouth	34,34N,25W	Cedar			x	x			B			
Price Cr.	C	1.7	Mouth	27,40N,6W	Gasconade			x	x			B			
Prime Cr.	C	2.2	Mouth	31,46N,9W	Callaway			x	x			B			
Primrose Cr.	C	2.0	Mouth	22,38N,4E	St. Francois			x	x			B			
Profits Cr.	C	2.0	Mouth	24,42N,12W	Cole			x	x			B			
Province Br.	P	1.2	Mouth	2,29N,25W	Lawrence			x	x			B			
Pruett Cr.	P	1.7	Mouth	16,38N,5W	Crawford			x	x			B			
Pruett Cr.	C	1.2	16,38N,5W	9,38N,5W	Crawford			x	x			B			
Pryor Cr.	C	3.2	Mouth	08,37N,32W	Vernon			x	x			B			
Pucket Br.	C	1.2	Mouth	12,38N,1E	Washington			x	x			B			
Pump Hollow	C	2.0	Mouth	16,40N,2W	Crawford			x	x			B	x		
Punch Cr.	C	1.3	Mouth	6,31N,9E	Bollinger			x	x			B			
Puncheon Cr.	C	2.9	Mouth	36,44N,6W	Gasconade			x	x			B			
Purcell Br.	C	3.2	Mouth	05,35N,25W	St. Clair	Cedar		x	x			B			
Puzzle Cr.	C	12.5	Mouth	25,57N,17W	Chariton	Macon		x	x			B			
Pyatt Hollow	C	2.0	Mouth	13,36N,3W	Crawford			x	x			B			
Quick Cr.	PI	1.8	Mouth	Sur 2658,46N,5W	Montgomery			x	x			B			
Quick Cr.	C	2.0	Sur 2658,46N,5W	32,46N,5W	Montgomery			x	x			B	x		
Rabbit Hollow	C	1.5	Mouth	14,38N,1E	Washington			x	x			B			
Raccoon Cr.	C	3.7	Mouth	5,61N,25W	Grundy			x	x			B	x		
Raccoon Hollow	C	1.0	Mouth	16,24N,11W	Ozark			x	x			B			
Rice Cr.	P	0.5	Mouth	21,37N,1E	Washington			x	x			B			
Ragan Br.	C	4.3	Mouth	20,36N,07W	Phelps			x	x			B			
Railey Cr.	C	7.4	Mouth	Reeds Spring	Stone			x	x			B	x		
Rainy Cr.	P	2.5	Mouth	7,39N,19W	Camden			x	x			A	x		
Rainy Cr.	C	1.5	7,39N,19W	13,39N,20W	Camden	Benton		x	x			[B]	x		
Ramsey Br.	P	6.5	Mouth	33,31N,13E	Cape Girardeau			x	x			B	x		
Ramsey Br.	C	1.0	33,31N,13E	28,31N,13E	Cape Girardeau			x	x			B			
Ramsey Cr.	C	8.9	Mouth	[Sur 1709(9), 52N,1E]	Pike			x	x			B			
Ramsey Cr.	P	6.3	Mouth	LG 1709,52N,1E	Scott			x	x			B			
Ramsey Cr. Div. Chan.	P	3.0	Mouth	1,29N,13E	Scott			x	x			B			
Rattlesnake Cr.	C	3.0	Mouth	3,56N,25W	Livingston			x	x			B			
Red Oak Cr.	P	5.2	Mouth	28,42N,4W	Franklin	Gasconade		x	x			B			
Red Oak Cr.	C	10.0	28,42N,4W	16,41N,5W	Gasconade			x	x			B			

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Reed Cr.	C	2.7	Mouth	11,37N,32W	Vernon			x	x			B			
Reese Fk.	C	[7.0]/6.6	Mouth	28,53N,12W	Monroe			x	x			B	x		
Reid Cr.	C	2.6	Mouth	5,38N,27W	St. Clair			x	x			B			
Reid Cr.	C	2.0	Mouth	Sur 1812,51N,2W	Lincoln			x	x			B			
Reid Cr.	C	2.3	Mouth	Sur 3093,35N,3E	Washington	Iron		x	x			B			
Reisobel Br.	C	1.2	Mouth	21,40N,6W	Gasconade			x	x			B			
Renfro Cr.	C	1.5	Mouth	14,49N,11W	Callaway			x	x			B			
Richland Cr.	C	0.5	Mouth	6,44N,6W	Gasconade			x	x			B			
Richland Cr.	C	4.3	Mouth	29,48N,9W	Callaway			x	x			B	x		
Richland Cr.	P	5.1	Mouth	Hwy. 87	Howard			x	x			B			
Richland Cr.	C	2.0	Hwy. 87	16,50N,17W	Howard			x	x			B			
Richland Cr.	P	8.7	[13,43N,19W] Mouth	17,44N,18W	Morgan			x	x			A	x		
Richland Cr.	C	10.0	17,44N,18W	22,43N,18W	Morgan			x	x			A	x		
Ricky Cr.	C	7.8	Mouth	14,39N,28W	St. Clair			x	x			B			
Riggin Br.	C	1.9	Mouth	21,60N,35W	Andrew			x	x			B			
Rings Cr.	P	5.2	Mouth	23,29N,4E	Wayne			x	x			A			
Rings Cr.	C	1.1	23,29N,4E	27,29N,4E	Wayne			x	x			B			
Rippee Cr.	P	4.5	Mouth	13,25N,15W	Douglas			x	x			B			
Rippee Cr.	C	2.0	13,25N,15W	14,25N,15W	Douglas			x	x			B			
Rising Cr.	P	1.2	Mouth	[Sur 3616,44N,10W]	Cole			x	x						
Rising Cr.	C	4.4	[19,44N,10W] LG 2616,44N,10W	36,44N,11W	Cole			x	x			B	x		
Rivaux Cr.	P1	2.2	Mouth	[21,44N,10W] LG 2621,44N,10W	Callaway			x	x			B			
Rivaux Cr.	C	3.5	[21,44N,10W] LG 2621,44N,10W	8,44N,10W	Callaway			x	x			B	x		
River aux Vases	P	21.6	Mouth	12,36N,7E	Ste. Genevieve			x	x			A			
River aux Vases	C	7.1	12,36N,7E	27,36N,7E	Ste. Genevieve			x	x			B			
[River des Peres]	P	[2.6]/6.4	Mouth	[Sur 1339,44N,6E] LG 2037,45N,6E	St. Louis City			x	x				x		
River des Peres Drainage Channel [River des Peres]	[P]	[3.7]	[Sur 1339,44N,6E]	[Sur 2037,45N,6E]	[St. Louis City]			[x]	[x]				[x]		
Roach Lake Cr.	C	0.7	Mouth	30,57N,24W	Livingston			x	x			B			
Roaring R.	P	6.5	Mouth	27,22N,27W	Barry			x	x		x	A	x		
Roaring Springs	P	0.1	Mouth	35,33N,10W	Texas			x	x			B			
Roark Br.	C	[1.3]/3.8	Mouth	[23,43N,14W] 2,43N,14W	Cole			x	x			B	x		
Roark Cr.	C	2.7	Mouth	36,23N,22W	Taney			x	x		x	A	x		
Roark Cr.	C	4.0	36,23N,22W	15,23N,22W	Taney			x	x			A	x		
Roberts Br.	C	2.0	Mouth	5,54N,32W	Clinton			x	x			B			
Robinson Br.	C	2.0	Mouth	30,36N,29W	Vernon			x	x			B			
Robinson Creek	P	3.1	Mouth	[Hwy B] 4,38N,6W	Phelps			x	x			B			
Rock Br.	C	3.1	Mouth	25,36N,3W	Crawford			x	x			B			
Rock Br.	P	2.0	State Line	12,26N,34W	Newton			x	x			B			

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Rock Cr.	C	1.0	Mouth	19,43N,11W	Cole			x	x			[B]	x		
Rock Cr.	C	3.0	Mouth	24,33N,12W	Texas			x	x			B			
Rock Cr.	P	5.8	Mouth	Sur 2970,42N,5E	Jefferson			x	x			B	x		
Rock Cr.	C	3.0	Sur 2970,42N,5E	Sur 1974,43N,5E	Jefferson			x	x			[B]	x		
Rock Cr.	P	2.2	Mouth	30,64N,41W	Atchison			x	x			B			
Rock Cr.	C	19.0	30,64N,41W	17,66N,40W	Atchison			x	x			B			
Rock Cr.	P	2.6	36,22N,26W	24,22N,26W	Barry			x	x			B			
Rock Cr.	C	4.6	24,22N,26W	8,22N,26W	Barry			x	x			B			
Rock Cr.	P	0.8	Mouth	19,34N,7E	Madison			x	x			B			
Rock Cr.	C	2.0	[Mouth]	9,34N,7E	Madison	St. Francois		x	x			B			
			20,34N,7E												
Rock Cr.	P	2.9	Mouth	16,33N,5E	Madison			x	x			B			
Rock Cr.	C	1.1	16,33N,5E	17,33N,5E	Madison			x	x			B			
Rock Cr.	C	3.4	Mouth	31,53N,31W	Clay			x	x			B			
Rock Cr.	C	4.8	Mouth	34,62N,12W	Knox			x	x			B			
Rock Cr.	P	0.5	Mouth	9,45N,13W	Cole			x	x			B			
Rock Cr.	C	4.0	9,45N,13W	18,45N,13W	Cole			x	x			B	x		
Rock Enon Cr.	C	3.3	Mouth	14,43N,15W	Moniteau			x	x			B			
Rockhouse Cr.	P	2.8	Mouth	14,23N,26W	Barry			x	x			B			
Rockhouse Cr.	C	4.3	14,23N,26W	28,23N,26W	Barry			x	x			B			
Rocky Br.	C	3.2	Mouth	11,52N,33W	Clay			x	x			B	x		
Rocky Br.	C	1.6	Mouth	10,32N,10W	Texas			x	x				x		
Rocky Br.	C	0.4	Mouth	[23,39N,02E]	Washington			x	x			B			
			23,39N,2E												
Rocky Br.	C	1.7	Mouth	16,43N,16W	Moniteau			x	x			B			
Rocky Cr.	P	2.4	Mouth	6,28N,2W	Shannon			x	x			B			
Rocky Cr.	C	2.7	Mouth	7,28N,8E	Wayne	Bollinger		x	x			B			
Rocky Fk.	C	11.3	Mouth	36,50N,13W	Boone			x	x			B	x		
Rocky Fk.	C	0.1	Mouth	04,35N,01W	Washington			x	x			B			
Rocky Fk.	C	4.0	Mouth	19,53N,28W	Ray			x	x			B			
Rocky Ford Cr.	P	3.0	Mouth	21,42N,18W	Morgan			x	x			B			
Rocky Hollow	C	1.2	Mouth	08,35N,29W	Vernon			x	x			B			
Rodgers Cr.	C	1.0	Mouth	7,39N,10W	Maries			x	x			B			
Rogers Cr.	C	9.6	Mouth	28,28N,02W	Carter			x	x			A			
Rollins Cr.	C	1.3	Mouth	16,38N,14W	Miller			x	x			B			
Rollins Cr.	C	7.0	Mouth	13,51N,29W	Ray			x	x						
Ross Cr.	P	3.0	Mouth	13,41N,21W	Benton			x	x			B			
Roth Cr.	C	1.8	Mouth	07,42N,01W	Franklin			x	x			B			
Roubidoux Cr.	P	4.0	Mouth	25,36N,12W	Pulaski			x	x		x	A	x		
Roubidoux Cr.	C	22.9	25,36N,12W	11,34N,12W	Pulaski			x	x	x		A	x		
Roubidoux Cr.	P	30.5	11,34N,12W	4,31N,11W	Pulaski	Texas		x	x	x		A	x		
Rubeneau Br.	C	1.8	Mouth	Sur 2115,37N,3E	Washington			x	x						
Rush Cr.	P	4.5	Mouth	22,51N,34W	Platte			x	x			B			
Rush Cr.	P	8.2	Mouth	5,51N,31W	Clay			x	x			A			
Rutledge Run	C	2.2	Mouth	15,35N,2E	Washington			x	x			B			
Rye Cr.	P	2.8	Mouth	23,41N,1E	Franklin			x	x			B			
Rye Cr.	C	1.0	23,41N,1E	26,41N,1E	Franklin			x	x			B			

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S. Ashley Cr.	P	5.0	Mouth	8,31N,7W	Dent	Texas		x	x			B			
S. Ashley Cr.	C	[2.0]/2.8	9,31N,7W	18,31N,7W	Texas			x	x			B			
S. Big Cr.	C	5.6	Mouth	Lake Viking Dam	Daviess			x	x			B			
S. Blackbird Cr.	C	[13.0]/14.1	Mouth	18,65N,18W	Putnam			x	x			B			
S. Bridges Cr.	C	4.0	Mouth	13,22N,11W	Ozark			x	x			B			
S. Brush Cr.	C	2.0	Mouth	12,53N,9W	Monroe			x	x			B			
S. Davis Cr.	C	4.6	Mouth	22,48N,27W	Lafayette			x	x			B			
S. Deepwater Cr.	C	11.9	Mouth	20,40N,29W	Bates			x	x			B			
S. Dry Sac R.	P	2.0	Mouth	3,29N,22W	Greene			x	x			B			
S. Dry Sac R.	C	4.2	3,29N,22W	5,29N,21W	Greene			x	x			[B]	x		
S. Fabius R.	P	80.6	Mouth	29,62N,11W	Marion	Knox	x	x	x			B			
S. Fk. Apple Cr.	P	5.5	Mouth	34,34N,10E	Cape Girardeau	Perry		x	x			B			
S. Fk. Apple Cr.	C	1.0	34,34N,10E	4,33N,10E	Perry			x	x			B			
S. Fk. Blackwater R.	P	5.7	Mouth	19,46N,27W	Johnson			x	x			B			
S. Fk. Blackwater R.	C	15.1	19,46N,27W	30,47N,28W	Johnson			x	x			B	x		
S. Fk. Bratten Spring Cr.	C	1.8	Mouth	19,22N,14W	Ozark			x	x			B			
S. Fk. Brush Cr.	C	5.5	Mouth	03,34N,24W	Polk			x	x			B			
S. Fk. Buffalo Cr.	P	2.0	Mouth	30,24N,1E	Ripley			x	x	x		B			
S. Fk. Buffalo Cr.	C	4.7	30,24N,1E	34,24N,1W	Ripley			x	x	x		B			
S. Fk. Capps Cr.	C	4.3	Mouth	27,25N,28W	Barry			x	x			B	x		
S. Fk. Cleat Cr.	C	6.0	Mouth	21,65N,36W	Nodaway			x	x			B			
S. Fk. Gees Cr.	C	2.8	Mouth	2,59N,25W	Livingston			x	x			B			
S. Fk. Isle Du Bois Cr.	C	4.0	Mouth	36,39N,6E	Ste. Genevieve			x	x			[B]	x		
S. Fk. Jonca Cr.	C	2.0	8,36N,7E	18,36N,7E	Ste. Genevieve			x	x			B			
S. Fk. M. Fabius R.	P	14.8	[22,64N,12W] Mouth	31,65N,13W	Scotland	Schuyler		x	x			B			
S. Fk. M. Fabius R.	C	13.0	31,65N,13W	Hwy. 63	Schuyler			x	x			B			
S. Fk. N. Fabius R.	C	11.5	Mouth	27,67N,15W	Schuyler			x	x			B			
S. Fk. North R.	P	6.9	Mouth	13,57N,8W	Marion			x	x			B			
S. Fk. North R.	C	[4.3]/7.2	13,57N,8W	[21,57N,8W] 19,57N,8W	Marion			x	x			B			
S. Fk. Pomme de Terre R.	P	5.0	Mouth	25,30N,20W	Greene			x	x			A	x		
S. Fk. S. Fabius R.	P	7.9	[29,62N,11W] Mouth	9,62N,12W	Knox			x	x			B			
S. Fk. S. Fabius R.	C	18.3	9,62N,12W	13,63N,14W	Knox	Adair		x	x			B	x		
S. Fk. S. Grand R.	C	14.2	Mouth	34,44N,33W	Cass			x	x			B			
S. Fk. Saline Cr.	P	[23.4]/23.2	Mouth	27,35N,9E	Perry			x	x	x		B			
S. Fk. Saline Cr.	C	[5.0]/4.7	27,35N,9E	[1,34N,8E] 36,35N,8E	Perry	Ste. Genevieve		x	x			B			
S. Fk. Salt R.	P	9.3	Mouth	[Audrain Co. Line] 29,53N,8W	Monroe		x	x	x			B	x		
S. Fk. Salt R.	C	[40.1]/40.3	29,53N,8W	5,49N,8W	Monroe	Callaway		x	x			B	x		
S. Fk. Spring Cr.	C	1.5	Mouth	13,26N,10W	Howell			x	x			B			
S. Fk. Spring R.	P	4.2	State Line	26,22N,8W	Howell			x	x			B			
S. Fk. Spring R.	C	11.0	26,22N,8W	32,23N,8W	Howell			x	x			B			
S. Fk. Turkey Cr.	C	4.5	21,35N,25W	34,35N,25W	Cedar			x	x			A			
S. Fk. Wenzelau Cr.	C	7.3	Mouth	20,36N,24W	St. Clair			x	x			A			
S. Flat Cr.	C	0.9	27,43N,22W	27,43N,22W	Benton			x	x			B			

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S. Flat Cr.	P	8.2	Mouth	27,43N,22W	Pettis	Benton		x	x			B			
S. Grand R.	P	66.8	Mouth	02,44N,33W	Henry	Cass		x	x			B	x		
S. Indian Cr.	P	8.7	Mouth	1,23N,30W	Newton	McDonald		x	x		x	B			
S. Moreau Cr.	P	21.1	1,43N,13W	29,43N,14W	Cole			x	x			A	x		
S. Moreau Cr.	C	10.2	29,43N,14W	7,42N,15W	Cole	Miller		x	x			A	x		
S. Moreau Cr.	C	6.5	7,42N,15W	36,42N,15W	Miller			x	x			B	x		
S. Mud Cr.	C	3.8	Mouth	2,54N,27W	Ray			x	x			B			
S. Prong Beaverdam Cr.	C	7.2	Mouth	27,25N,3E	Ripley			x	x			B			
S. Prong Jacks Fk.	P	7.0	Mouth	21,28N,8W	Texas			x	x			B			
S. Prong Jacks Fk.	C	[4.5]/5.6	21,28N,8W	[14,28N,9W] 11,28N,9W	Texas			x	x			B			
S. Prong L. Black R.	P	5.5	Mouth	Hwy. 21	Ripley			x	x			B			
S. Prong L. Black R.	C	6.0	Hwy. 21	33,25N,2E	Ripley			x	x			B			
S. Rock Br.	C	3.2	Mouth	14,35N,3W	Crawford			x	x			B			
S. Spencer Cr.	C	9.3	Mouth	6,53N,4W	Ralls	Pike		x	x			[B]	x		
S. Spring Cr.	P	4.0	Mouth	23,25N,16W	Douglas			x	x			B			
S. Wyacorda R.	P	9.7	26,65N,9W	4,65N,10W	Clark	Scotland		x	x			B		x	
S. Wyacorda R.	C	17.5	4,65N,10W	32,67N,12W	Scotland			x	x			B			
Sac R.	P	48.8	Mouth	Stockton Lake Dam	St. Clair	Cedar		x	x	x		A	x		
Sac R.	P	[35.0]/33.3	[1,31N,26W] 5,31N,25W	15,29N,24W	Dade	Greene		x	x	x		A	x		
Sac R.	C	3.5	15,29N,24W	19,29N,23W	Greene			x	x			B			
Sadler Br.	C	0.8	Mouth	17,35N,24W	Polk			x	x			B			
Salem Cr.	C	2.0	Mouth	26,37N,5E	St. Francois			x	x			[B]	x		
Salem Springs Cr.	C	1.0	Mouth	11,32N,17W	Laclede			x	x			B			
Saline Cr.	P	13.8	Mouth	10,41N,15W	Miller			x	x			A	x		
Saline Cr.	P	11.0	Mouth	[13,36N,9E] LG 3015,36N,9E	Ste. Genevieve	Perry		x	x			A			
Saline Cr.	P	15.0	[13,36N,9E] LG 3015,36N,9E	[16,33N,8E] LG 3204,35N,8E	Ste. Genevieve			x	x	x		A			
Saline Cr.	C	4.0	16,35N,8E	11,35N,7E	Ste. Genevieve			x	x			B			
Saline Cr.	P	4.3	Mouth	32,35N,3E	Iron			x	x			B			
Saline Cr.	P	1.8	Mouth	[Sur 3011,43N,5E] LG 3011,43N,5E	Jefferson			x	x			B			
Saline Cr.	C	2.3	[Sur 3011,43N,5E] LG 3011,43N,5E	[Sur 1331,43N,5E] LG 1331,43N,5E	Jefferson			x	x			B	x		
Saline Cr.	P	5.8	Mouth	12,33N,7E	Madison			x	x			B			
Saline Cr.	C	1.1	12,33N,7E	7,33N,7E	Madison			x	x			B			
Salley Br.	C	0.1	Mouth	27,39N,22W	Benton			x	x			B			
Sals Cr.	C	1.5	Mouth	14,29N,13E	Scott			x	x			B			
Sals Cr. Div. Chan.	C	2.7	Mouth	3,29N,13E	Scott			x	x			B			
Salt Br.	C	[5.7]/4.1	Mouth	35,53N,21W	Saline			x	x			B			
Salt Br.	C	7.2	Mouth	20,50N,22W	Saline			x	x			B			
Salt Cr.	C	5.0	Mouth	9,38N,26W	St. Clair			x	x			B			
Salt Cr.	C	14.9	Mouth	25,55N,20W	Chariton			x	x			B			
Salt Cr.	PI	3.0	Mouth	33,49N,15W	Howard			x	x			B			
Salt Cr.	C	10.0	33,49N,15W	31,50N,15W	Howard			x	x			B			

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Salt Cr.	P	3.1	Mouth	[6,49N,17W] LG 3328,49N,17W	Howard			x	x			B			
Salt Fk.	C	7.2	Mouth	2,51N,15W	Howard			x	x			B			
Salt Fk.	P	26.7	Mouth	28,51N,22W	Saline			x	x			B	x		
Salt Fk.	C	18.6	28,51N,22W	29,50N,24W	Saline	Lafayette		x	x			B			
Salt Pine Cr.	C	1.2	Mouth	[5,38N,3E] LG 3039,39N,3E	Washington			x	x			B			
Salt Pond Cr.	P	3.6	Mouth	25,49N,23W	Saline			x	x			B			
Salt Pond Cr.	C	2.4	25,49N,23W	14,49N,23W	Saline			x	x			B			
Salt R.	P1	9.3	[Re-Reg Dam]	[Cannon Dam] 9,55N,6W	Rails		x	x	x			A	x	x	
Salt R.	P1	15.0	Mouth	Hwy. 79	Pike		x	x	x			A	x		
Salt R.	P	29.0	Hwy. 79	Re-Reg Dam	Pike	Rails	x	x	x			A	x	x	
Sampson Cr.	P	13.5	Mouth	19,62N,29W	Daviess	Harrison		x	x			B			
Sampson Cr.	C	5.6	19,62N,29W	1,62N,30W	Gentry			x	x			B			
Sand Cr.	C	15.0	Mouth	12,43N,26W	Henry			x	x			B			
Sand Cr.	C	4.9	Mouth	11,64N,37W	Nodaway			x	x			B			
Sand Cr.	C	1.8	Mouth	[34,36N,06E] 34,36N,6E	St. Francois			x	x			B			
Sand Cr.	P	1.6	Mouth	18,42N,4E	Jefferson			x	x			B			
Sand Cr.	C	2.4	Mouth	36,65N,16W	Schuyler			x	x			B			
Sand Hollow	C	0.3	Mouth	24,31N,10W	Texas			x	x			B			
Sand Run	C	2.0	Mouth	24,48N,1W	Lincoln			x	x			B	x		
Sandy Cr.	C	7.0	Mouth	27,52N,2W	Lincoln	Pike		x	x			B			
Sandy Cr.	C	[7.5]/10.3	Mouth	[Sur 1987,41N,5E] LG 1976,41N,4E	Jefferson			x	x			B	x		
Sandy Cr.	C	1.3	Mouth	1,34N,10E	Perry			x	x			[B]	x		
Sandy Cr.	P	2.4	Mouth	11,33N,11E	Cape Girardeau			x	x			B			
Sandy Cr.	C	0.5	11,33N,11E	3,33N,11E	Cape Girardeau			x	x			B			
Sandy Cr.	C	6.0	Mouth	23,51N,5W	Montgomery	Audrain		x	x			B			
Sandy Cr.	C	13.8	Mouth	25,50N,1E	Lincoln			x	x			B	x		
Sandy Cr.	C	11.6	Mouth	15,65N,25W	Harrison	Mercer		x	x			B			
Sandy Cr.	C	3.0	Mouth	19,66N,17W	Putnam			x	x			B			
Sanford Cr.	C	1.0	Mouth	4,43N,10W	Cole			x	x			B			
[Sara Br.]	C	2.5	Mouth	01,32N,18W	Webster			x	x			B			
Sarah Br.															
Sardine Cr.	C	1.8	Mouth	2,29N,25W	Lawrence			x	x			B			
Sawmill Hollow	C	2.6	Mouth	17,24N,11W	Ozark			x	x			B			
Sawyer Cr.	P	5.5	Mouth	1,28N,20W	Greene			x	x			B			
Schawanee Spr. Br.	C	2.8	Mouth	5,34N,11E	Perry			x	x			B			
School Hollow Cr.	P	1.3	Mouth	08,41N,09W	Osage			x	x			B			
Schoolhouse Hollow	C	0.3	Mouth	[19,31N,09W] 19,31N,9W	Texas			x	x			B			
Schole Cr.	P	2.9	Mouth	LG 1669,46N,3E	St. Charles			x	x			B			
Schulte Cr.	P	0.5	Mouth	8,43N,5W	Groesbeade			x	x			B			
Schultz Cr.	C	5.0	Mouth	10,32N,21W	Polk			x	x			B			
Scott Br.	C	1.5	Mouth	21,37N,2W	Crawford			x	x			B			
Scott Br.	C	1.2	Mouth	5,37N,1E	Washington			x	x			B			
Scott Br.	C	0.5	Mouth	5,44N,15W	Moniteau			x	x						

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Second Cr.	P	8.0	Mouth	12,43N,6W	Gasconade			x	x			B			
Second Cr.	C	6.5	12,43N,6W	[Hwy. 19]	Gasconade			x	x			B			
				27,43N,5W											
Second Cr.	C	11.5	Mouth	29,52N,33W	Clay	Platte		x	x			B			
Second Nicolson Cr.	P	4.5	4,32N,33W	18,32N,33W	Barton			x	x			B			
Sees Cr.	C	1.0	Mouth	22,57N,7W	Marion			x	x			B			
Sees Cr.	P	1.0	Mouth	15,57N,7W	Marion			x	x			B			
Sees Cr.	C	[2.2]/1.3	15,57N,7W	22,57N,7W	Marion			x	x			B			
Sellars Cr.	C	[3.5]/4.0	Mouth	6,36N,14W	Camden			x	x			A	x		
Sellers Hollow	C	5.3	Mouth	7,37N,15W	Camden			x	x			[B]	x		
Selph Br.	P	1.0	Mouth	23,31N,20W	Greene			x	x			B			
Selvaige Hollow	C	2.4	Mouth	21,33N,16W	Laclede			x	x			B			
Sewer Br.	C	1.0	Mouth	16,46N,21W	Pettis			x	x			B			
Shackelford Br.	C	5.9	Mouth	21,52N,29W	Ray			x	x			B			
Shady Cr.	C	9.4	Mouth	[5,52N,5W]	Pike			x	x			[B]	x		
				14,52N,5W											
Shady Cr.	C	1.9	Mouth	31,45N,6E	St. Louis			x	x					x	
Shain Cr.	C	13.0	Mouth	[Hwy. 46]	Harrison			x	x			B			
				13,66N,28W											
Sharpsburg Br.	C	[1.5]/6.3	Mouth	[28,57N,8W]	Marion			x	x			[B]	x		
				11,56N,8W											
Shaver Cr.	P	15.1	Mouth	06,45N,20W	Pettis			x	x			B			
Shaw Br.	C	[1.2]/2.0	Mouth	[Sur 3272,36N,5E]	St. Francois			x	x			[B]	x		
				20,36N,5E											
Shawnee Cr.	P	3.2	Mouth	8,33N,13E	Cape Girardeau			x	x			B			
Shawnee Cr.	P	2.0	Mouth	30,29N,3W	Shannon			x	x			B			
Shawnee Cr.	C	6.5	30,29N,03W	19,28N,03W	Shannon			x	x			B			
Shawnee Cr.	C	1.5	9,45N,7W	16,45N,7W	Osage			x	x			B			
Shawnee Cr.	P	4.5	Mouth	9,45N,7W	Gasconade	Osage		x	x			B			
Shays Cr.	C	1.7	Mouth	33,34N,7E	Madison			x	x			B			
Sheep Cr.	C	1.0	Mouth	1,56N,29W	Caldwell			x	x			B			
Shell Br.	C	5.3	Mouth	8,55N,8W	Monroe			x	x			B			
Shetley Cr.	C	2.7	12,31N,7E	2,31N,7E	Madison			x	x			B			
Shetley Cr.	P	4.0	Mouth	12,31N,7E	Madison			x	x			B			
Shibboleth Br.	P	1.0	Mouth	14,38N,3E	Washington			x	x			B			
Shibboleth Br.	C	3.0	14,38N,3E	21,38N,3E	Washington			x	x			B			
Shipley Slough	C	2.5	35,19N,9E	24,19N,9E	Dunklin			x	x			B			
Shoal Cr.	P	7.7	Mouth	27,36N,2W	Crawford			x	x			A			
Shoal Cr.	C	3.0	27,36N,2W	10,35N,2W	Crawford			x	x			B	x		
Shoal Cr.	C	3.1	Mouth	31,22N,17W	Taney			x	x			A	x		
Shoal Cr.	P	[41.1]/50.5	State Line	[27,26N,30W]	Newton		x	x	x	x		A	x	x	x
				10,25N,29W											
Shoal Cr.	P	0.5	10,25N,29W	[Capps Cr.]	Newton		x	x	x	x		A	x		
				15,25N,29W											
Shoal Cr.	P	15.7	[9,25N,29W]	12,23N,29W	Newton	Barry	x	x	x	x		A	x		
			15,25N,29W												
Shoal Cr.	C	5.0	12,23N,29W	32,23N,28W	Barry			x	x			B			
Shoal Cr.	P	10.3	Mouth	27,51N,32W	Clay			x	x			B			
Shoal Cr.	C	10.6	27,51N,32W	2,51N,33W	Clay			x	x			B			

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Shoal Cr.	P	54.6	Mouth	25,56N,28W	Livingston	Caldwell		x	x			A	x	x	
Shoal Cr.	C	34.0	25,56N,28W	5,55N,30W	Caldwell	Clinton		x	x			B	x		
Shoal Cr.	C	17.4	Mouth	5,66N,17W	Putnam			x	x			B			
Shoal Cr. Ditch	C	9.8	27,57N,24W	28,56N,25W	Livingston			x	x			B			
Shootman Cr.	C	1.5	Mouth	6,53N,22W	Carroll			x	x			B			
Short Cr.	P	2.9	Mouth	30,22N,21W	Taney			x	x			B			
Short Cr.	C	0.9	30,22N,21W	36,22N,22W	Taney			x	x			B			
Shrum Cr.	P	1.7	Mouth	6,33N,10E	Bollinger			x	x			B			
Shrum Cr.	C	1.0	6,33N,10E	County Line	Bollinger			x	x			B			
Shuld Br.	C	2.0	Mouth	23,28N,9W	Texas			x	x			B			
Shuteye Cr.	C	4.5	Mouth	31,64N,16W	Adair			x	x			B			
Shut-in Cr.	P	1.8	Mouth	6,33N,2E	Reynolds			x	x			B			
Shut-in Cr.	C	3.3	6,33N,2E	20,34N,2E	Iron			x	x			B			
Shuyler Cr.	P	3.6	Mouth	28,28N,23W	Greene			x	x			B			
Silver Cr.	P	1.9	Mouth	25,27N,33W	Newton			x	x			B			
Silver Cr.	C	1.8	Mouth	01,23N,21W	Taney			x	x			B			
Silver Cr.	C	8.4	Mouth	34,53N,15W	Chariton	Randolph		x	x			B			
Silver Fk.	C	30.0	Mouth	33,51N,11W	Boone			x	x			A			
Silver Lake Br.	C	2.0	Mouth	13,26N,23W	Stone			x	x			B			
Simms Cr.	C	2.6	Mouth	15,37N,27W	St. Clair			x	x			B			
Simpson Br.	C	2.0	Mouth	6,38N,2E	Washington			x	x			B			
Sims Br.	C	1.3	Mouth	26,31N,22W	Greene			x	x			B			
Sinking Cr.	P	2.3	Mouth	10,30N,26W	Dade			x	x			B			
Sinking Cr.	C	2.0	10,30N,26W	12,30N,26W	Dade			x	x			B			
Sinking Cr.	P	5.2	12,30N,26W	16,30N,25W	Dade			x	x			B			
Sinking Cr.	P	24.0	Mouth	8,32N,3W	Shannon	Dent		x	x	x		A			
Sinking Cr.	P	19.9	Mouth	19,31N,1E	Reynolds			x	x			B			
Sitton Br.	P	0.8	Mouth	12,50N,2W	Lincoln			x	x			B			
Sitton Br.	C	2.8	12,50N,2W	10,50N,2W	Lincoln			x	x			B			
Skinner Cr.	C	1.3	Mouth	[09,42N,03W]	Franklin			x	x			B			
Skull Cr.	C	0.5	Mouth	9,42N,3W	Cooper			x	x			B			
Skullbones Cr.	C	1.1	Mouth	10,47N,19W	Jefferson			x	x			B			
Slabtown Br.	C	3.7	Mouth	35,42N,03E	Texas			x	x			B			
Slagle Cr.	P	8.2	Mouth	23,33N,10W	Polk			x	x			B			
Slagle Cr.	P	2.2	Mouth	17,32N,22W	Bollinger			x	x			B			
Slater Br.	C	[2.0]/2.2	Mouth	18,28N,9E	Madison			x	x			B			
Slater Br.	C	3.7	Mouth	[Sur 1852,33N,6E]	Inspere			x	x			B			
Slim Chute	P	2.2	Mouth	LG 1852,33N,6E	Pike			x	x			B			
Smiley Cr.	C	3.0	Mouth	34,30N,32W	Cooper			x	x			B			
Smith Br.	C	3.6	Mouth	8,52N,2E	Montgomery			x	x			B			
Smith Br.	C	0.5	Mouth	36,46N,17W	Callaway			x	x			B			
Smith Cr.	C	1.5	Mouth	18,48N,5W	Callaway			x	x			B			
Smith Cr.	C	12.0	Mouth	16,47N,9W	Monitenu	Morgan		x	x			A			
Smith Fk.	C	3.0	Mouth	26,47N,11W	Clinton			x	x			B			
Smith Hollow	C	1.0	Mouth	2,43N,17W	Ozark			x	x			B			
Smith Hollow Cr.	P	1.1	Mouth	15,56N,31W	Phelps			x	x			B			

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Smith Hollow Cr.	C	1.9	Mouth	36,37N,10W	Phelps			x	x			B			
Snag Br.	C	2.4	Mouth	21,34N,27W	Cedar			x	x			B			
Snapps Br.	C	1.5	Mouth	2,36N,1W	Washington			x	x			B			
Sni-a-bar Cr.	C	4.3	30,48N,29W	5,47N,29W	Jackson			x	x			B			
Sni-a-bar Cr.	P	36.6	Mouth	30,48N,29W	Lafayette	Jackson		x	x			B	x		
Snowden Br.	C	2.0	Mouth	1,32N,7E	Madison			x	x			B			
Snyder Ditch	C	6.5	26,24N,7E	26,25N,7E	Butler			x	x			B			
Soap Cr.	P	1.0	Mouth	32,41N,17W	Morgan			x	x			B			
Soap Cr.	P	0.8	Mouth	19,42N,04W	Gasconade			x	x			B			
Soap Cr.	C	4.5	19,42N,04W	11,42N,05W	Gasconade			x	x			B	x		
Sons Cr.	P	1.5	Mouth	27,32N,27W	Dade			x	x			B			
Sons Cr.	C	10.8	27,32N,27W	31,31N,27W	Dade			x	x			B			
South Cr.	P	3.8	Mouth	34,29N,22W	Greene			x	x			B			
South Fk.	C	4.5	Mouth	25,24N,15W	Ozark			x	x			B			
South Fk. Blackwater R.	C	17.1	Mouth	08,46N,23W	Saline	Pettis		x	x			B			
South R.	P	2.6	Mouth	16,58N,5W	Marion			x	x			B			
South R.	C	16.3	16,58N,5W	33,57N,6W	Marion			x	x			B			
Sparrow Foot Cr.	C	2.6	Mouth	15,41N,25W	Henry			x	x			B			
Spence Cr.	C	3.6	1,28N,15W	19,28N,15W	Wright			x	x			B			
Spencer Cr.	C	2.3	Mouth	14,37N,17W	Camden			x	x			[B]	x		
Spencer Cr.	C	1.5	Mouth	Sur 1786,47N,4E	St. Charles			x	x				x		
Spencer Cr.	P	[11.0]/10.5	Mouth	[31,55N,4W]	Ralls			x	x			B			
Spencer Cr.	C	[24.0]/22.2	[31,55N,4W]	23,53N,6W	Ralls			x	x			B	x		
Spillway Ditch	P	[24.7]/12.6	28,23N,15E	[33,25N,16E]	New Madrid	Mississippi		x	x			A			
Spillway Ditch	C	[8.7]/11.7	5,24N,16E	[25,26N,16E]	Mississippi			x	x			B			
Splice Cr.	P	3.6	Mouth	7,47N,14W	Moniteau			x	x			A	x		
Splice Cr.	C	2.5	7,47N,14W	11,47N,15W	Moniteau			x	x			B			
Spring Alee Hollow	P	1.5	Mouth	29,30N,2W	Shannon			x	x			B			
Spring Alee Hollow	C	1.3	29,30N,2W	21,30N,2W	Shannon			x	x			B			
Spring Br.	P	1.0	Mouth	19,41N,17W	Morgan			x	x		x	B			
Spring Br.	P	1.9	Mouth	4,29N,22W	Greene			x	x			B			
Spring Cr.	P	5.8	Mouth	8,34N,24W	Cedar	Polk		x	x			B			
Spring Cr.	P	[5.4]/15.3	Mouth	[17,39N,8W]	Maries			x	x			B			
Spring Cr.	P	7.4	Mouth	15,38N,8W	Phelps		x	x	x		x	A	x		
Spring Cr.	P	16.0	31,35N,9W	16,33N,9W	Phelps	Texas		x	x			B			
Spring Cr.	C	3.7	16,33N,9W	26,33N,9W	Texas			x	x				x		
Spring Cr.	P	[18.0]/13.0	Mouth	[19,34N,05W]	Dent			x	x			B	x		
Spring Cr.	P	2.7	Mouth	19,34N,5W	Franklin			x	x		x	B			
Spring Cr.	C	5.1	4,41N,2W	17,41N,2W	Franklin			x	x			B	x		
Spring Cr.	P	6.5	Mouth	12,26N,24W	Stone			x	x		x	B			
Spring Cr.	P	5.2	Mouth	14,23N,11W	Ozark			x	x			B	x		
Spring Cr.	P	7.5	14,23N,11W	17,23N,10W	Ozark	Howell		x	x			A	x		x

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WATER BODY	CLASS	MILES	FROM	TO	COUNTY	COUNTY 2	IRR	LWW	AQL	CLF	CDF	WBC	SCR	DWS	IND
Spring Cr.	C	8.9	17,23N,10W	6,23N,9W	Howell			x	x			B			
Spring Cr.	P	19.2	Mouth	23,26N,10W	Douglas	Howell		x	x			B	x		
Spring Cr.	P	6.0	Mouth	06,24N,13W	Douglas	Ozark		x	x		x	B	x		
Spring Cr.	C	5.3	6,24N,13W	8,24N,14W	Ozark			x	x			B			
Spring Cr.	C	1.0	Mouth	30,23N,8W	Howell			x	x			B			
Spring Cr.	P	8.5	Mouth	24,25N,5W	Oregon			x	x			B			
Spring Cr.	C	5.8	24,25N,5W	3,25N,5W	Oregon			x	x			B			
Spring Cr.	C	4.0	Mouth	[28,49N, 01W]	Lincoln			x	x			B			
Spring Cr.	P	18.7	Mouth	28,49N,1W 26,64N,18W	Adair	Sullivan		x	x	x		A			
Spring Cr.	C	5.0	26,64N,18W	19,64N,18W	Sullivan			x	x			B	x		
Spring Cr.	P	1.0	Mouth	18,25N,16W	Douglas			x	x			B			
Spring Cr. Ditch	C	4.4	27,25N,9E	10,25N,9E	Stoddard			x	x			B			
Spring Fk.	C	6.3	16,44N,21W	[01,43N,21W]	Pettis	Benton		x	x			B			
Spring Fk.	P	5.4	Mouth	1,43N,21W 16,44N,21W	Pettis			x	x			B			
Spring Hollow	C	11.4	Bennett Springs	27,34N,17W	[Laclede]	Laclede		x	x		x	B			
Spring R.	P	0.5	22,28N,34W	15,28N,34W	Jasper			x	x	x	x	A	x		x
Spring R.	P	61.7	State Line	20,28N,27W	Jasper	Lawrence		x	x	x	x	A	x		x
Spring R.	P	8.8	20,28N,27W	13,27N,27W	Lawrence			x	x	x	x	A	x		x
Spring R.	P	11.9	13,27N,27W	28,26N,26W	Lawrence			x	x			A	x		
Spring R.	C	1.0	28,26N,26W	27,26N,26W	Lawrence			x	x			B			
Spring Valley Cr.	P	10.8	Mouth	35,30N,5W	Shannon			x	x			B			
Spring Valley Cr.	C	[10.0/24.9	35,30N,5W	[6,29N,5W]	Shannon			x	x			B			
Spurlock Hollow	C	2.7	Mouth	23,29N,7W 15,30N,11W	Texas	Texas		x	x			B			
Squaw Cr.	P	21.0	36,61N,39W	33,64N,38W	Holt	Atchison		x	x			B			
St. Francis R.	P	[93.1/101.9	[13,28N, 5E]	16,35N,4E	Wayne	St. Francois		x	x	x	x	A	x		
St. Francis R.	C	3.8	16,35N,4E	10,27N,6E	Ozark Ore Lake Dam	St. Francois		x	x			B			
St. Francis R.	P	104.0	State Line	Wappapello Dam	Dunklin	Wayne		x	x	x		A	x		
St. James Ditch	C	2.1	11,23N,15E	1,23N,15E	New Madrid			x	x			B			
St. Johns Bayou	P	[4.7/5.3	Mouth	28,23N,15E	New Madrid			x	x			B			
St. Johns Cr.	P	21.0	Mouth	12,43N,2W	Franklin			x	x			B			
St. Johns Cr.	C	9.0	12,43N,2W	19,43N,2W	Franklin			x	x			B	x		
St. Johns Ditch	C	4.7	36,28N,13E	Sur 1014,28N,14E	Scott			x	x	x		A			
St. Johns Ditch	P	15.3	Mouth	16,25N,14E	New Madrid			x	x			B	x		
St. Johns Ditch	P	18.7	16,25N,14E	36,28N,13E	New Madrid	Scott		x	x				x		
St. Johns Diversion Ditch	C	[5.0/10.3	[11,23N,15E]	[9,23N,16E]	New Madrid			x	x			B			
[St. Johns Diversion Ditch]	[C	[4.3]	[4,23N,16E]	[12,23N,16E]	[Mississippi]	Mississippi		[x]	[x]			[B]			
Stall Cr.	P	7.3	Mouth	25,29N,27W	Lawrence			x	x			B			
Stanley Cr.	P	3.1	Mouth	18,27N,8E	Wayne			x	x			B			
Starks Cr.	P	10.3	Mouth	12,37N,21W	Hickory			x	x	x		B			
Starks Cr.	C	7.0	12,37N,21W	31,37N,20W	Hickory			x	x	x		B			
Starvey Cr.	C	3.0	Mouth	15,32N,18W	Dallas			x	x			B			
Stater Cr.	P	2.4	Mouth	27,40N,2W	Crawford			x	x			B			

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Stater Cr.	C	2.3	27,40N,2W	29,40N,2W	Crawford			x	x			[B]	x		
Steins Cr.	C	16.6	25,33N,15W	33,31N,15W	Laclede	Wright		x	x			B	x		
Stephens Br.	C	8.8	Mouth	29,47N,17W	Cooper			x	x			B	x		
Sterett Cr.	C	1.2	Mouth	21,41N,22W	Benton			x	x			B			
Steuber Hollow Cr.	P	0.6	Mouth	13,41N,09W	Osage			x	x			B			
Stevensan Bayou	C	[6.4]/1.1	[25,26N,16E]	31,27N,17E	Mississippi			x	x			B	x		
			1,26N,16E												
Stewart Cr.	P	1.0	Mouth	12,27N,19W	Christian			x	x			B			
Stewart Cr.	C	3.0	12,27N,19W	17,27N,18W	Christian			x	x			B			
Stick Br.	C	0.4	Mouth	21,36N,21W	Hickory			x	x			B			
Stillcamp Ditch	C	12.3	Mouth	35,24N,6E	Butler		x	x	x			B			
Stillhouse Br.	C	2.0	Mouth	26,62N,31W	Gentry			x	x			B			
Stinking Cr.	C	4.7	Mouth	5,34N,28W	Cedar			x	x			B			
Stinking Cr.	C	1.4	Mouth	22,35N,22W	Polk			x	x			B			
Stinking Cr.	C	15.8	[24,56N,16W]	[Mouth]	Macon			x	x			B			
			Mouth	13,58N,16W											
Stinson Cr.	C	11.9	Mouth	16,47N,9W	Callaway			x	x			B	x		
Stoak Cr.	C	2.3	Mouth	14,45N,26W	Johnson			x	x			B			
Stockton Br.	C	3.6	Mouth	4,34N,26W	Cedar			x	x			B	x		
Stone Hill Br.	C	2.3	Mouth	35,34N,4W	Dent			x	x			B			
Stone Hill Br.	P	2.2	35,34N,4W	31,34N,3W	Dent			x	x			B			
Storys Cr.	C	2.7	Mouth	16,29N,4W	Shannon			x	x			B			
Stouts Cr.	P	7.3	Mouth	33,34N,4E	Madison	Iron	x	x	x	x		B	x		
Stouts Cr.	P	4.0	33,34N,4E	1,33N,3E	Iron			x	x			B	x		
Stouts Cr.	C	1.1	1,33N,3E	2,33N,3E	Iron			x	x			B			
Straight Fk.	P	12.0	4,44N,16W	6,43N,17W	Moniteau	Morgan		x	x			A			
Straight Fk.	C	6.0	6,43N,17W	36,43N,18W	Morgan			x	x			B			
Stream Mill Hollow	P	3.0	Mouth	27,32N,10W	Texas			x	x			B			
Stream Mill Hollow	C	2.0	27,32N,10W	28,32N,10W	Texas			x	x					x	
String Cr.	C	2.0	Mouth	20,45N,14W	Moniteau			x	x			B			
Stringtown Br.	C	1.5	Mouth	12,36N,1W	Washington			x	x			B			
Strobel Br.	P	0.7	Mouth	1,44N,14W	Cole			x	x			B	x		
Strobel Br.	C	2.0	[12,44N,14W]	35,45N,14W	Cole			x	x			B			
			1,44N,14W												
Strobel Br.	C	2.4	Mouth	24,44N,14W	Cole			x	x			B			
Strotler Cr.	P	[6.0]/6.9	Mouth	[33,34N,1W]	Reynolds	Iron		x	x	x		B			
				5,33N,1W											
Sugar Br.	P	2.3	Mouth	12,48N,14W	Boone			x	x			B			
Sugar Br.	C	3.0	12,48N,14W	3,48N,14W	Boone			x	x			B			
Sugar Cr.	C	1.6	Mouth	17,51N,13W	Boone			x	x			B			
Sugar Cr.	P	9.5	Mouth	23,41N,11W	Miller	Maries			x	x		B			
Sugar Cr.	C	13.8	Mouth	33,44N,30W	Cass			x	x			B			
Sugar Cr.	C	11.0	Mouth	Sur 1683,50N,1E	Lincoln			x	x			B			
Sugar Cr.	C	3.8	Mouth	33,45N,6W	Gasconade			x	x			B			
Sugar Cr.	C	5.5	Mouth	20,43N,5E	Jefferson			x	x			B	x		
Sugar Cr.	P	3.0	Mouth	2,54N,37W	Platte			x	x			B			
Sugar Cr.	C	6.5	2,54N,37W	28,55N,36W	Platte	Buchanan		x	x			B			
Sugar Cr.	PI	3.8	Mouth	18,64N,6W	Clark			x	x			B			

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Sugar Cr.	C	10.2	18,64N,6W	29,65N,7W	Clark			x	x			B			
Sugar Cr.	C	12.0	Mouth	15,62N,7W	Lewis			x	x			B	x		
Sugar Cr.	P	8.0	Mouth	22,62N,26W	Grundy	Harrison		x	x			B			
Sugar Cr.	C	12.0	22,62N,26W	35,63N,27W	Harrison			x	x			B			
Sugar Cr.	C	6.3	Mouth	18,61N,15W	Adair			x	x			B			
Sugar Cr.	P	6.8	Mouth	Sugar Cr. Lake Dam	Randolph			x	x			B			
Sugar Cr.	C	1.5	Mouth	36,55N,3W	Pike			x	x			B			
Sugar Fk.	P	1.0	Mouth	5,23N,33W	McDonald			x	x			B			
Sugar Tree Br.	C	3.5	Mouth	34,52N,15W	Howard			x	x			B			
Sugarcamp Hollow	C	2.5	Mouth	17,23N,26W	Barry			x	x				x		
Sulphur Cr.	P	2.1	Mouth	15,51N,2W	Lincoln			x	x			B			
Sulphur Cr.	C	9.3	15,51N,2W	19,52N,2W	Lincoln	Pike		x	x			B	x		
Sulphur Cr.	C	1.8	Mouth	30,52N,2W											
Sulphur Cr.	P	5.5	Mouth	9,31N,4E	Iron			x	x			B			
Sulphur Cr.	C	7.0	Mouth	30,49N,16W	Howard			x	x			B			
Sulphur Cr.	C	7.0	30,49N,16W	26,50N,17W	Howard			x	x			B			
Summers Cr.	C	1.0	Mouth	19,32N,9E	Bollinger			x	x			B			
Surratt Cr.	C	1.2	Mouth	26,25N,19W	Christian			x	x			B			
Sutton Br.	P	0.5	Mouth	35,32N,2E	Reynolds			x	x			B			
Sutton Cr.	P	1.0	Mouth	12,29N,4W	Shannon			x	x			B			
Sutton Hollow	C	0.5	Mouth	36,31N,3E	Iron			x	x			B			
Swan Cr.	C	2.2	Mouth	8,42N,8W	Osage			x	x			B			
Swan Cr.	P	36.8	Mouth	4,26N,18W	Taney	Christian	x	x	x	x		A	x		
Swan Cr.	C	2.0	4,26N,18W	34,27N,18W	Christian	Douglas		x	x			B			
Swede Br.	C	0.4	Mouth	32,37N,21W	Hickory			x	x			B			
Sweet Hollow	C	2.7	Mouth	27,36N,17W	Laclede			x	x			B			
Sweet Spring Cr.	C	11.2	Mouth	18,53N,14W	Randolph			x	x			B	x		
Sweeten Cr.	C	1.6	Mouth	26,22N,13W	Ozark			x	x			B			
Sweetwater Br.	P	1.0	Mouth	30,34N,7E	Madison			x	x			B			
Sweetwater Br.	C	1.7	30,34N,7E	28,34N,7E	Madison			x	x			B			
Sweetwater Cr.	P	3.0	Mouth	28,31N,2W	Reynolds			x	x			B			
Sweezer Cr.	C	4.9	Mouth	20,58N,15W	Macon			x	x			B			
Swift Cr.	C	1.0	Mouth	15,26N,5E	Butler			x	x			B			
Swift Ditch	C	4.0	26,23N,14E	2,23N,14E	New Madrid			x	x			B			
Sycamore Br.	P	4.5	Mouth	7,29N,26W	Lawrence			x	x			B			
Sycamore Cr.	P	3.7	Mouth	20,29N,24W	Greene			x	x			B			
Sycamore Cr.	C	1.0	Mouth	15,27N,3W	Shannon			x	x			B			
Tabo Cr.	P	11.4	Mouth	27,50N,26W	Lafayette			x	x			B			
Tabo Cr.	C	8.4	27,50N,26W	20,49N,26W	Lafayette			x	x			B			
Tabor Cr.	P	5.6	Mouth	9,24N,10W	Douglas	Howell		x	x			B			
Tabor Cr.	C	3.7	9,24N,10W	11,24N,10W	Howell			x	x			B			
Tanyard Cr.	C	4.0	Mouth	9,50N,16W	Howard			x	x			B			
Tarbutton Cr.	P	2.0	Mouth	4,26N,14W	Douglas			x	x			B			
Tarkio R.	P	33.5	Mouth	State Line	Holt	Atchison	x	x	x			B	x	x	
Tater Hill Cr.	C	7.7	Mouth	27,55N,24W	Carroll			x	x			B			
Taum Sauk Cr.	C	4.0	Mouth	14,33N,2E	Reynolds			x	x			B			
Tavern Cr.	P	39.2	Mouth	5,38N,12W	Miller			x	x	x		A	x		

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Tavern Cr.	C	10.6	5,38N,12W	12,37N,13W	Miller	Pulaski		x	x	x		A			
Tavern Cr.	P	2.7	Mouth	12,44N,2E	Franklin			x	x			B			
Taylor Br.	C	1.2	Mouth	27,36N,6E	St. Francois			x	x			B			
Teague Br.	C	5.8	Mouth	1,33N,27N	Cedar			x	x			B			
Teho Cr.	P	4.0	Mouth	6,42N,24W	Henry			x	x			B			
Tebo Cr.	C	0.5	6,42N,24W	31,43N,24W	Henry			x	x			B			
Tebo Cr.	C	3.1	Mouth	19,44N,21W	Pettis			x	x			B			
Teeter Cr.	C	3.0	Mouth	20,25N,14W	Douglas			x	x			B			
Ten Mile Cr.	P	1.7	Mouth	36,58N,12W	Shelby			x	x			B			
Tennile Cr.	P	9.3	Mouth	10,25N,4E	Butler			x	x			A	x		
Tennile Cr.	C	14.2	10,25N,4E	29,26N,3E	Butler	Carter		x	x			A	x		
Tennile Pond	C	5.1	28,24N,16E	2,24N,16E	Mississippi			x	x			B			
Tennessee Cr.	C	8.0	Mouth	34,44N,31W	Cass			x	x			B			
Terrell Br.	P	2.2	Mouth	17,28N,18W	Webster			x	x			B			
Terre Bleue Cr.	P	6.3	Mouth	Sur 2107,37N,5E	St. Francois			x	x	x		A			
Terre Bleue Cr.	C	6.0	Sur 2107,37N,5E	Sur 2097,37N,6E	St. Francois			x	x			B			
Terrell Cr.	P	1.0	Mouth	2,27N,23W	Christian			x	x		x	B			
Terrell Cr.	P	3.7	2,27N,23W	5,27N,23W	Christian			x	x			B			
Terrell Cr.	C	1.0	5,27N,23W	6,27N,23W	Christian			x	x			B			
Terrell Cr.	P	1.0	6,27N,23W	1,27N,24W	Christian			x	x			B			
Thief Cr.	C	3.6	Mouth	12,66N,16W	Schuyler			x	x			B			
Third Cr.	P	4.5	Mouth	5,42N,6W	Osage	Gasconade		x	x			B			
Third Cr.	C	6.5	5,42N,6W	7,42N,5W	Gasconade			x	x			B			
[Third Fk. Platte R.]	C	33.7	Mouth	25,61N,33W	Buchanan	Gentry		x	x			B	x		
Third Fk.															
Thomas Crute	P	2.4	LG 1729,52N,2E	23,52N,2E	Pike			x	x			A	x		
Thomas Cr.	C	8.8	Mouth	3,35N,20W	Hickory	Dallas		x	x			B			
Thompson Br.	C	1.0	Mouth	1,62N,31W	Gentry			x	x			B			
Thompson Br.	C	0.5	Mouth	[5,47N,14W]	Moniteau			x	x			B			
Thompson Cr.	C	1.6	Mouth	6,47N,14W	Daviess			x	x			B			
Thompson R.	P	70.6	Mouth	12,59N,27W	Livingston	Harrison	x	x	x			B		x	
Three Hill Cr.	C	4.4	Mouth	State Line	St. Francois			x	x			B	x		
Threemile Cr.	C	2.4	Mouth	7,37N,4E	Franklin	Crawford		x	x			B			
Thurnan Cr.	P	3.0	Mouth	21,40N,4W	Newton			x	x			B			
Tick Cr.	C	4.4	Mouth	30,27N,32W	Phelps			x	x			[B]	x		
Tiff Cr.	P	[2.1]/4.5	Mouth	28,38N,9W	Jefferson			x	x			B			
Tiger Fk.	C	14.0	Mouth	[04,38N,04E]	Shelby			x	x			B			
Titus Cr.	C	0.8	Mouth	10,38N,4E	Macon			x	x			B			
Tobin Cr.	C	8.0	Mouth	1,60N,14W	Scotland			x	x			B			
Toby Hollow	C	1.7	Mouth	34,65N,12W	Camden			x	x			B			
Todd Cr.	C	9.9	Mouth	Toby Sprg.	Platte			x	x			B	x		
Todd Hollow	C	0.5	Mouth	15,52N,34W	Crawford			x	x			B			
Todd Hollow	C	1.0	Mouth	34,35N,3W	Crawford			x	x			B			
Tombstone Cr.	P	2.7	Mouth	3,36N,2W	Harrison			x	x			B			
Tombstone Cr.	C	3.9	Mouth	26,62N,26W	Harrison			x	x			[B]	x		

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Toms Cr.	C	2.2	Mouth	10,32N,2W	Reynolds			x	x				x		
Tory Cr.	P	2.8	Mouth	27,26N,22W	Stone	Christian		x	x		x	B			
Town Br.	P	0.8	Mouth	13,36N,1W	Washington			x	x			B			
Town Br.	C	1.8	13,36N,1W	18,36N,1E	Washington			x	x			B			
Town Br.	P	2.5	Mouth	12,33N,23W	Polk			x	x			B			
Townsend Slough	C	1.7	Mouth	21,37N,32W	Vernon			x	x			B			
Towstring Cr.	C	7.7	Mouth	20,56N,22W	Livingston			x	x			B			
Tr. to Blue Shawnee Cr.	C	1.8	Mouth	21,33N,13E	Cape Girardeau			x	x			B			
[Tr. to Bois Brule Ditch]	C	1.0	[Mouth]	[Sur 1870,36N,11E]	Perry			x	x			B			
Trib. to Bois Brule Cr.			9,36N,11E	LG 1879,36N,11E											
Tr. to Isle du Bois Cr.	C	1.0	Mouth	14,39N,6E	Stc. Genevieve			x	x			B			
Tr. to N. Pt. Beaverdam Cr.	C	1.0	Mouth	19,25N,4E	Ripley			x	x			B			
Tr. to O. Ch. Nishnabotna R.	C	0.9	Mouth	17,64N,41W	Atchison			x	x			B			
Tr. to O. Ch. Nishnabotna R.	C	2.0	Mouth	30,66N,41W	Atchison			x	x			B			
Tr. to Woods Fk. Gasconade	C	2.3	2,29N,16W	15,29N,16W	Wright			x	x			B			
Trace Cr.	P	1.3	Mouth	1,35N,1W	Washington			x	x			B			
Trace Cr.	C	1.3	1,35N,1W	6,35N,1E	Washington			x	x			B			
Trace Cr.	C	6.2	Mouth	29,32N,6E	Madison			x	x			B			
Trace Cr.	P	4.0	Mouth	4,30N,8E	Wayne	Bollinger		x	x	x		B			
Trace Cr.	C	3.4	4,30N,8E	26,31N,8E	Bollinger	Madison		x	x			B			
Trail Cr.	C	4.0	Mouth	10,24N,12W	Ozark			x	x			B			
Trail Cr.	P	4.7	Mouth	Hwy. 136	Harrison			x	x			B			
Trail Cr.	C	5.0	Hwy. 136	19,64N,26W	Harrison			x	x			B			
Trib to Bates Cr.	C	1.0	Mouth	16,37N,02E	Washington			x	x			B			
Trib to Coon Cr.	C	0.5	Mouth	2,45N,22W	Pettis			x	x				x		
Trib to Coon Cr.	C	1.8	Mouth	12,45N,22W	Pettis			x	x			[B]	x		
Trib to Crabapple Cr.	C	1.3	Mouth	2,53N,26W	Ray			x	x			B			
Trib to E. Fk Post oak Cr.	C	2.0	Mouth	34,45N,26W	Johnson			x	x			B			
Trib to E. Fk Post oak Cr.	C	3.9	Mouth	23,44N,26W	Johnson			x	x			B	x		
[Trib to L. Whitewater Cr.]	C	1.0	16,33N,9E	17,33N,9E	Bollinger			x	x			B			
Trib. to L. Whitewater Cr.															
Trib to Poinne de Terre Res.	C	1.5	Mouth	30,36N,22W	Hickory			x	x			B			
Trib to Roubidoux Cr.	C	3.6	Mouth	7,33N,11W	Pulaski	Texas		x	x			B			
[Trib to trib to Bois Brule Ditch]	C	1.6	9,36N,11E	[Sur 147,37N,11E]	Perry			x	x			[B]	x		
Trib. to Trib. to Bois Brule Cr.				LG 147,37N,11E											
Trib to Trib. to S. Moreau Cr.	C	1.2	Mouth	30,43N,15W	Moniteau			x	x			B			
Trib. Headwater Div.	P	1.5	Mouth	31,30N,12E	Cape Girardeau			x	x			B			
Trib. Headwater Div.	C	1.0	31,30N,12E	36,30N,11E	Cape Girardeau			x	x			B			
Trib. M. Fk. Big Cr.	C	1.6	Mouth	24,31N,6E	Madison			x	x			B			
Trib. M. Fk. Grand R.	C	1.4	Mouth	State Line	Worth			x	x			B			
Trib. M. Fk. Salt R.	C	1.0	Mouth	22,59N,14W	Macon			x	x			B			
Trib. M. Fk. Tebo Cr.	C	[1.7]/5.0	[19,43N,24W] Mouth	[17,43N,24W] 3,43N,24W	Henry			x	x			B			

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[Trib. M. Fk. Tebo Cr.]	[C]	[0.5]	[9,43N,24W]	[3,43N,24W]	[Henry]			[x]	[x]			[B]			
Trib. M. Fk. Tebo Cr.	C	0.5	Mouth	5,43N,24W	Henry			x	x			B			
Trib. M. Fk. Tebo Cr.	C	3.1	Mouth	36,44N,25W	Henry			x	x			B			
Trib. Old Mines Cr.	C	1.5	Mouth	32,39N,3E	Washington			x	x			B			
Trib. to Alley Br.	C	1.6	Mouth	22,29N,5W	Shannon			x	x			B			
Trib. to Apple Cr.	C	4.7	Mouth	Hwy. 51	Perry			x	x			B			
Trib. to Apple Cr.	C	2.1	Mouth	16,34N,10E	Perry			x	x			B			
Trib. to Atwell Cr.	C	3.2	Mouth	05,38N,11W	Miller	Maries		x	x			B			
Trib. to Baileys Cr.	C	0.8	Mouth	[06,45N,06W]	Gasconade			x	x			B			
				6,45N,6W											
Trib. to Baileys Cr.	P	0.8	Mouth	[32,45N,07W]	Osage			x	x			B			
				32,45N,7W											
Trib. to Baileys Cr.	C	0.5	Mouth	27,45N,7W	Osage			x	x			B			
Trib. to Ball Br.	C	0.4	Mouth	33,40N,4E	Jefferson			x	x			B			
Trib. to Barkers Cr.	C	1.0	Mouth	15,42N,24W	Henry			x	x			B			
Trib. to Barn Hollow	C	1.3	Mouth	4,27N,7W	Texas	Howell		x	x			B			
Trib. to Barren Fk.	C	1.0	Mouth	31,39N,13W	Miller			x	x			B			
Trib. to Barren Fork	C	1.5	Mouth	[36,44N,05W]	Gasconade			x	x			B			
				36,44N,5W											
Trib. to Basin Fk.	C	3.7	Mouth	23,44N,23W	Pettis			x	x			B			
Trib. to Basin Fk.	C	3.1	Mouth	36,45N,23W	Pettis			x	x			B			
Trib. to Bauer Br.	C	3.0	Mouth	28,43N,21W	Benton			x	x			B			
Trib. to Bear Br.	C	1.9	Mouth	28,25N,16W	Douglas			x	x			B	x		
Trib. to Bear Cr.	C	0.8	Mouth	15,64N,10W	Scotland			x	x			B			
Trib. to Bear Cr.	C	0.6	15,64N,10W	21,64N,10W	Scotland			x	x			B	x		
Trib. to Beaver Cr.	C	1.0	Mouth	25,29N,12W	Texas			x	x			B			
Trib. to Beaver Cr.	C	1.0	Mouth	23,24N,18W	Taney			x	x			B			
Trib. to Beaverdam Cr.	C	0.7	Mouth	25,47N,23W	Pettis			x	x			B			
Trib. to Beaverdam Cr.	C	0.8	Mouth	24,47N,23W	Pettis			x	x			B			
Trib. to Bee Cr.	C	1.8	Mouth	3,54N,35W	Platte			x	x			B			
Trib. to Bee Run	C	0.1	Mouth	24,38N,4E	St. Francois			x	x			B			
Trib. to Beeleer Br.	C	1.4	Mouth	29,28N,10W	Texas			x	x			B			
Trib. to Belew Cr.	C	1.2	Mouth	LG 3027,41N,4E	Jefferson			x	x			B			
Trib. to Benton Cr.	P	0.7	Mouth	5,36N,5W	Crawford			x	x			B			
Trib. to Big Berger Cr.	C	0.8	Mouth	35,45N,4W	Franklin			x	x			B			
Trib. to Big Br.	C	1.2	Mouth	14,44N,04W	Franklin			x	x			B			
Trib. to Big Buffalo Cove	C	0.8	Mouth	35,41N,20W	Benton			x	x			B			
Trib. to Big Buffalo Cr.	C	0.6	Mouth	12,41N,20W	Benton			x	x			B			
Trib. to Big Cr.	C	3.0	Mouth	4,29N,8W	Texas			x	x			B			
Trib. to Big Cr.	C	2.2	Mouth	2,29N,8W	Texas			x	x			B			
Trib. to Big Cr.	C	1.0	Mouth	24,31N,3E	Iron			x	x			B			
Trib. to Big Cr.	C	1.4	Mouth	33,32N,3E	Iron			x	x			B			
Trib. to Big Cr.	C	1.0	Mouth	9,42N,3W	Franklin			x	x			B			
Trib. to Big Cr.	C	2.0	Mouth	12,42N,4W	Franklin			x	x			B			
Trib. to Big Deer Cr.	C	1.8	Mouth	3,41N,31W	Bates			x	x			B			
Trib. to Big Lake Bayou	C	3.1	Mouth	19,27N,16E	Mississippi			x	x			B			
Trib. to Big Otter Cr.	C	1.0	Mouth	32,40N,25W	Henry			x	x			B			
Trib. to Big R.	C	1.0	Mouth	26,39N,3E	Washington			x	x			[B]	x		

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Trib. to Big R.	C	1.0	Mouth	2,36N,3E	Washington		x	x				B			
Trib. to Big R.	C	1.9	Mouth	27,43N,4E	Jefferson		x	x				B			
Trib. to Billies Cr.	C	2.1	Mouth	10,29N,25W	Lawrence		x	x				B			
Trib. to Bird Br.	C	0.6	Mouth	14,41N,22W	Benton		x	x							
Trib. to Black Cr.	C	0.2	30,58N,10W	19,58N,10W	Shelby		x	x				B	x		
Trib. to Black R.	C	2.0	Mouth	11,30N,2E	Reynolds		x	x				B			
Trib. to Blackwater R.	C	1.1	Mouth	24,48N,22W	Saline	Pettis	x	x				B			
Trib. to Blackwater R.	C	0.7	Mouth	19,48N,22W	Saline	Pettis	x	x				B			
Trib. to Blackwater R.	C	0.5	Mouth	21,48N,23W	Pettis		x	x				B			
Trib. to Blackwater R.	C	1.7	Mouth	29,48N,23W	Pettis		x	x				B			
Trib. to Blair Br.	C	0.9	Mouth	8,61N,8W	Lewis		x	x				B			
Trib. to Boeuf Cr.	C	1.5	Mouth	35,45N,3W	Franklin		x	x				B			
Trib. to Boeuf Cr.	C	1.5	Mouth	17,44N,3W	Franklin		x	x				B			
Trib. to Boeuf Cr.	C	1.2	Mouth	17,44N,2W	Franklin		x	x				B			
Trib. to Boeuf Cr.	C	0.2	Mouth	[12,43N,04W]	Franklin		x	x				B			
Trib. to Boeuf Cr.	C	1.3	Mouth	[12,43N,4W] [08,42N,04W]	Gasconade		x	x				B	x		
Trib. to Bois Brule Cr.	C	0.9	Mouth	8,42N,4W	Cole		x	x				B			
Trib. to Bois Brule Cr.	C	0.7	Mouth	15,42N,13W	Cole		x	x				B			
[Trib. to Bois Brule Ditch]	P	1.7	Mouth	24,42N,13W	Cole		x	x				B			
Trib. to Bois Brule Cr.				[4,36N,11E]	Perry		x	x				B			
				9,36N,11E											
Trib. to Boone Cr.	C	0.3	Mouth	15,40N,03W	Crawford		x	x				B			
Trib. to Bourbeuse R.	C	[2.0] 2.4	[14,40N,06W]	[Hwy. B]	Gasconade		x	x				B			
Trib. to Bourbeuse R.	P	0.2	Mouth	14,40N,6W	Gasconade		x	x				B			
				[14,40N,06W]											
Trib. to Bourbeuse R.	C	0.7	Mouth	14,40N,6W	Phelps		x	x				B			
Trib. to Bourbeuse R.	C	0.5	Mouth	23,38N,7W	Franklin		x	x				B			
Trib. to Bourbeuse R.	C	0.4	Mouth	1,42N,3W	Franklin		x	x				A			
Trib. to Brazeau Cr.	P	2.2	Mouth	27,42N,3W	Perry		x	x				B			
Trib. to Brazeau Cr.	C	1.0	7,34N,13E	12,34N,12E	Perry		x	x				B			
Trib. to Brewers Cr.	C	0.5	Mouth	19,34N,5E	Madison		x	x				B			
Trib. to Bridge Cr.	C	3.7	Mouth	26,63N,12W	Knox		x	x				B			
Trib. to Brock Cr.	C	1.0	Mouth	35,36N,1E	Washington		x	x				B			
Trib. to Brush Cr.	C	1.9	Mouth	15,42N,23W	Benton		x	x				B			
Trib. to Brush Cr.	C	1.7	Mouth	24,42N,9W	Osage		x	x				B			
Trib. to Brush Cr.	C	1.5	Mouth	19,42N,8W	Osage		x	x				B			
Trib. to Brush Cr.	C	1.0	Mouth	34,40N,5W	Crawford		x	x				B			
[Trib. to Brush Cr.]	C	[1.0] 1.5	Mouth	25,40N,5W	Crawford		x	x				B			
Souder Creek															
Trib. to Brush Cr.	C	1.4	Mouth	30,36N,25W	St. Clair		x	x				B			
Trib. to Brush Cr.	C	0.4	Mouth	28,36N,25W	St. Clair		x	x				B			
Trib. to Brush Cr.	C	0.1	Mouth	26,39N,05W	Crawford		x	x				B			
Trib. to Brush Cr.	C	1.0	Mouth	34,43N,14W	Cole		x	x				B			
Trib. to Brushy Cr.	C	3.6	Mouth	23,57N,30W	Caldwell	Clinton	x	x				B	x		
Trib. to Bryant Cr.	C	1.8	Mouth	14,24N,13W	Ozark		x	x				B			
Trib. to Bryants Cr.	C	3.0	Mouth	17,51N,1E	Lincoln		x	x				B			

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Trib. to Bryants Cr.	C	1.7	Mouth	20,51N,1E	Lincoln			x	x			B			
Trib. to Buckeye Cr.	C	1.2	Mouth	26,33N,12E	Cape Girardeau			x	x			B			
Trib. to Bucklick Cr.	C	1.5	Mouth	24,44N,3W	Franklin			x	x			B			
Trib. to Bucklick Cr.	C	1.3	Mouth	29,44N,2W	Franklin			x	x			B			
Trib. to Burris Fk.	C	0.5	Mouth	3,43N,16W	Moniteau			x	x			B			
Trib. to Burris Fk.	C	0.5	Mouth	34,44N,16W	Moniteau			x	x			B			
Trib. to Busch Cr.	C	3.0	Mouth	34,44N,1W	Franklin			x	x				x		
Trib. to Busch Cr.	C	1.8	Mouth	35,44N,1W	Franklin			x	x			B		x	
Trib. to Butcher Cr.	C	1.0	Mouth	22,48N,1E	Lincoln			x	x			B			
Trib. to Byrd Cr.	C	1.0	Mouth	[Sur 2236,32N,12E]	Cape Girardeau			x	x			B			
				LG 2236,32N,12E											
Trib. to Camp Br.	C	1.0	Mouth	24,45N,22W	Pettis			x	x			B			
Trib. to Camp Br.	C	0.7	Mouth	23,45N,22W	Pettis			x	x			B			
Trib. to Camp Br.	C	0.8	Mouth	29,45N,22W	Pettis			x	x			B			
Trib. to Camp Cr.	C	1.1	Mouth	20,36N,6E	St. Francois			x	x			B			
Trib. to Cane Cr.	P	1.3	Mouth	Sur 2138,32N,12E	Cape Girardeau			x	x			B			
Trib. to Cane Cr.	C	0.8	Mouth	10,26N,4E	Butler			x	x			B			
Trib. to Cane Cr.	C	1.0	Mouth	8,26N,4E	Butler			x	x			B			
Trib. to Cane Cr.	C	1.2	Mouth	35,26N,4E	Butler			x	x			B			
Trib. to Caney Cr.	C	1.9	Mouth	12,24N,17W	Taney			x	x			A			
Trib. to Cape La Croix Cr.	C	1.7	Sur	11,31N,13E	Cape Girardeau			x	x						
				3314,31N,13E											
Trib. to Capps Cr.	P	1.0	Mouth	14,25N,29W	Newton			x	x			B			
Trib. to Carr Br.	C	0.1	Mouth	4,54N,8W	Monroe			x	x			B			
Trib. to Castile Cr.	C	1.2	Mouth	3,56N,32W	Clinton			x	x			B			
Trib. to Castor R.	P	1.8	Mouth	5,28N,9E	Bollinger			x	x			B			
Trib. to Castor R.	C	0.5	5,28N,9E	[Hwy. 51]	Bollinger			x	x			B			
				6,28N,9E											
Trib. to Castor R.	C	1.5	Mouth	16,28N,10E	Bollinger	Stoddard		x	x			B			
Trib. to Castor R.	C	1.0	Mouth	25,34N,7E	Madison			x	x			B			
Trib. to Castor R.	P	3.0	Mouth	23,34N,7E	Madison			x	x			B			
Trib. to Cat Br.	C	0.5	Mouth	15,57N,12W	Shelby			x	x			B			
Trib. to Cedar Cr.	C	0.5	Mouth	32,46N,11W	Callaway			x	x			B			
Trib. to Center Cr.	C	1.0	Mouth	21,27N,29W	Newton			x	x			B			
Trib. to Cherry Valley Cr.	C	1.2	Mouth	9,37N,3W	Crawford			x	x			B			
Trib. to Clark Fk.	C	0.5	Mouth	15,47N,16W	Cooper			x	x						
Trib. to Clear Cr.	C	1.1	Mouth	10,41N,23W	Benton			x	x			B			
Trib. to Clear Cr.	C	1.0	Mouth	21,36N,2E	Washington			x	x			B			
Trib. to Clear Cr.	C	0.4	Mouth	23,44N,25W	Johnson			x	x			B			
Trib. to Clear Cr.	C	1.6	Mouth	[26,39N,06W]	Phelps			x	x			B			
				26,39N,6W											
Trib. to Clear Cr.	C	1.7	Mouth	05,34N,30W	Vernon			x	x			B			
Trib. to Clear Cr.	C	0.9	Mouth	28,42N,23W	Benton			x	x			B			
Trib. to Clear Cr.	C	1.8	Mouth	32,34N,30W	Vernon			x	x			B			
Trib. to Clear Cr.	C	2.2	Mouth	15,54N,31W	Clinton			x	x			B			
Trib. to Clear Fk.	C	0.8	Mouth	15,44N,25W	Johnson			x	x			[B]	x		
Trib. to Clear Fk.	C	2.0	Mouth	04,44N,25W	Johnson			x	x			B			

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Trib. to Coon Cr.	C	2.0	Mouth	32,54N,13W	Randolph			x	x			B			
[Trib. to Coopers Cr.]	C	3.2	Mouth	4,39N,26W	St. Clair			x	x			B			
Trib. to Couper Cr.															
Trib. to Courtois Cr.	C	1.2	Mouth	31,37N,1W	Washington			x	x			B			
Trib. to Crane Cr.	C	0.9	Mouth	14,36N,21W	Hickory			x	x			B			
Trib. to Crane Cr.	C	0.8	Mouth	15,36N,21W	Hickory			x	x			B			
Trib. to Crane Cr.	C	1.9	Mouth	2,36N,21W	Hickory			x	x			B			
Trib. to Crane Cr.	C	1.0	Mouth	29,37N,21W	Hickory			x	x			B			
Trib. to Crane Cr.	C	0.2	Mouth	01,36N,21W	Hickory			x	x			B			
Trib. to Crane Cr.	C	0.4	Mouth	01,36N,21W	Hickory			x	x			B			
Trib. to Crane Cr.	C	0.1	Mouth	31,37N,21W	Hickory			x	x			B			
Trib. to Crider Cr.	C	0.9	Mouth	11,41N,7W	Osage			x	x			B			
Trib. to Crooked Cr.	C	1.0	Mouth	31,37N,4W	Crawford			x	x			B			
Trib. to Crooked Cr.	P	1.0	Mouth	Lk Girardeau Dam	Cape Girardeau			x	x			B			
Trib. to Crooked Cr.	C	1.5	9,30N,11E	5,30N,11E	Cape Girardeau			x	x			B			
Trib. to Crooked Cr.	C	1.0	Mouth	14,30N,10E	Bollinger			x	x			B			
Trib. to Crooked Cr.	C	0.7	Mouth	32,30N,11E	Cape Girardeau			x	x			B			
Trib. To Cub Cr.	C	1.9	Mouth	17,35N,1E	Washington			x	x			B			
Trib. to Davis Cr.	C	3.0	Mouth	3,61N,38W	Holt			x	x					x	
Trib. to Davis Cr.	C	0.3	Mouth	23,51N,9W	Audrain			x	x			B			
Trib. to Deer Cr.	P	1.0	Mouth	33,45N,08W	Osage			x	x			B			
Trib. to Deer Cr.	C	1.9	[33,45N,08W]	[04,44N,08W]	Osage			x	x			B			
Trib. to Deer Cr.	P	0.3	Mouth	33,45N,8W											
Trib. to Deer Cr.				4,44N,8W											
Trib. to Deer Cr.				[06,39N,20W]	Benton			x	x			B			
Trib. to Deer Cr.	P	0.8	Mouth	6,39N,20W											
Trib. to Deer Cr.	P	0.8	Mouth	28,40N,20W	Benton			x	x			B			
Trib. to Dillard Cr.	C	1.5	Mouth	20,31N,11E	Cape Girardeau			x	x			B			
Trib. to Dry Cr.	C	1.0	Mouth	15,36N,3W	Crawford			x	x			B			
Trib. to Dry Cr.	C	1.8	Mouth	36,37N,3W	Crawford			x	x			B			
Trib. to Dry Cr.	C	4.8	Mouth	20,25N,9W	Howell			x	x			B			
Trib. to Dry Cr.	C	2.2	Mouth	10,25N,9W	Howell			x	x			B			
Trib. to Dry Cr.	C	0.8	Mouth	14,36N,3E	Washington			x	x			B			
Trib. to Dry Fork	C	2.0	Mouth	34,37N,07W	Phelps			x	x			B			
Trib. to Dry Fork	C	0.4	Mouth	[27,38N,06W]	Phelps			x	x			B			
Trib. to Dry Fork				27,38N,6W											
Trib. to Dum Spring Cr.	C	1.5	Mouth	Sur 976,44N,1E	Franklin			x	x			B			
Trib. to E. Brush Cr.	C	0.5	Mouth	3,45N,15W	Moniteau			x	x			B			
Trib. to E. Fk. Crooked R.	C	4.8	Mouth	24,54N,28W	Ray			x	x			B		x	
Trib. to E. Fk. Huzzah Cr.	C	1.0	Mouth	30,34N,2W	Dent			x	x			B			
Trib. to E. Fk. L. Blue R.	P	1.9	Mouth	Lk. Tapawingo Dam	Jackson			x	x			B			
Trib. to E. Fk. Lost Cr.	P	1.0	Mouth	2,27N,7E	Wayne			x	x			B			
Trib. to E. Fk. Lost Cr.	C	1.0	2,27N,7E	2,27N,7E	Wayne			x	x			B			
Trib. to E. Fk. Rock Cr.	C	1.0	Mouth	18,22N,25W	Barry			x	x			B			
Trib. to E. Fk. Rock Cr.	C	1.0	Mouth	11,22N,26W	Barry			x	x			B			
Trib. to E. Fk. Sni-a-bar	C	3.8	Mouth	22,48N,28W	Lafayette			x	x			B		x	
Trib. to E. Fk. Sni-a-bar	C	2.7	Mouth	19,48N,28W	Lafayette			x	x			B			
Trib. to East Cr.	C	1.3	Mouth	32,46N,32W	Cass			x	x			B			
Trib. to Edmondson Cr.	C	3.1	Mouth	15,52N,20W	Saline			x	x			B			

IRR LWW AQL CLF CDF WBC SCR DWS IND

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Trib. to Elk Br.	C	0.2	Mouth	32,46N,22W	Pettis			x	x			B			
Trib. to Elk Fk.	C	0.2	Mouth	16,44N,23W	Pettis			x	x			B			
Trib. to Factory Cr.	P	0.5	Mouth	2,46N,14W	Moniteau			x	x			B			
Trib. to Factory Cr.	C	0.5	2,46N,14W	35,47N,14W	Moniteau			x	x			B			
Trib. to Factory Cr.	C	0.9	Mouth	29,47N,14W	Moniteau			x	x			B	x		
Trib. to First Cr.	C	2.0	Mouth	28,45N,5W	Gasconade			x	x			B			
Trib. to Flat Cr.	C	2.2	Mouth	26,22N,28W	Barry			x	x			B			
Trib. to Flat Cr.	C	3.2	Mouth	15,45N,20W	Pettis			x	x			B	x		
Trib. to Flat Cr.	C	1.8	Mouth	18,45N,20W	Pettis			x	x			B			
Trib. to Flat Cr.	C	1.5	Mouth	18,45N,21W	Pettis			x	x			B			
Trib. to Flat Cr.	C	1.8	Mouth	24,45N,22W	Pettis			x	x			B			
Trib. to Flat Cr.	C	0.9	Mouth	10,44N,22W	Pettis			x	x			B			
Trib. to Flat Cr.	C	1.4	Mouth	19,44N,22W	Pettis			x	x			B			
Trib. to Flat Cr.	C	2.7	Mouth	07,43N,22W	Pettis			x	x			B			
Trib. to Flat Cr.	C	1.0	Mouth	14,43N,23W	Pettis	Benton		x	x			B			
Trib. to Fleck Cr.	C	2.5	Mouth	28,32N,33W	Barton			x	x			B			
Trib. to Fourche a DuClos Cr.	C	1.0	Mouth	31,38N,7E	Ste. Genevieve			x	x			B			
Trib. to Fox R.	C	0.5	Mouth	27,66N,8W	Clark			x	x			B			
Trib. to Frene Cr.	C	0.5	Mouth	10,45N,5W	Gasconade			x	x			B			
Trib. to Gasconade R.	C	2.2	Mouth	24,44N,7W	Gasconade	Osage		x	x			B			
Trib. to Gasconade R.	C	0.5	26,29N,16W	34,29N,16W	Wright			x	x			B			
Trib. to Gasconade R.	C	1.4	Mouth	2,38N,9W	Phelps			x	x			B			
Trib. to Gizzard Cr.	C	1.0	Mouth	1,29N,10E	Bollinger			x	x			B			
Trib. to Goose Cr.	C	3.0	Mouth	18,28N,25W	Lawrence			x	x			B			
Trib. to Goose Pond Ditch	C	1.0	Mouth	4,26N,9E	Stoddard			x	x			B			
Trib. to Greasy Cr.	C	2.0	Mouth	15,21N,29W	Barry			x	x			B			
Trib. to Greedy Cr.	P	0.2	Mouth	Hwy B	Gasconade			x	x			B			
Trib. to Grindstone Cr.	C	1.0	Mouth	9,57N,30W	DeKalb			x	x			B			
Trib. to Hamilton Cr.	C	0.9	Mouth	29,40N,1W	Washington			x	x			B			
Trib. to Haw Cr.	P	1.0	Mouth	19,43N,19W	Morgan			x	x			B			
Trib. to Haw Cr.	C	1.0	Mouth	26,43N,20W	Benton			x	x			B			
Trib. to Hazel Cr.	C	0.8	Mouth	22,36N,1E	Washington			x	x			B			
Trib. to Heaths Cr.	C	3.9	Mouth	[28,47N,22W]	Pettis			x	x			B			
				21,47N,22W											
Trib. to Heaths Cr.	C	2.0	Mouth	20,47N,22W	Pettis			x	x			B			
Trib. to Heaths Cr.	C	1.1	Mouth	[08,47N,21W]	Pettis			x	x			B			
				8,47N,21W											
Trib. to Heaths Cr.	C	0.5	Mouth	32,48N,21W	Pettis			x	x			B			
Trib. to Henry Cr.	C	1.2	Mouth	31,44N,21W	Pettis	Benton		x	x			B			
Trib. to Hess Cr.	C	0.7	Mouth	18,47N,21W	Pettis			x	x			B			
Trib. to Hickory Cr.	C	0.6	Mouth	9,60N,25W	Grundy			x	x			B			
Trib. to Higgins Cr.	C	0.5	Mouth	34,43N,12W	Cole			x	x			B			
Trib. to High Cr.	C	2.0	Mouth	[14,66N,41W]	Atchison			x	x			B			
				11,66N,41W											
Trib. to Hinch Cr.	C	1.0	Mouth	34,39N,2W	Crawford			x	x			B			
Trib. to Hinkson Cr.	C	0.5	Mouth	2,49N,12W	Boone			x	x			B			
Trib. to Hogan Fk.	C	2.0	Mouth	13,44N,27W	Johnson			x	x			B			

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Trib. to Hogles Cr.	C	1.0	Mouth	26,39N,24W	St. Clair			x	x			B			
Trib. to Hogles Cr.	C	3.3	Mouth	22,37N,23W	Hickory			x	x			B			
Trib. to Hogles Cr.	C	1.1	Mouth	32,39N,23W	Benton			x	x			B			
Trib. to Honey Run	C	0.8	Mouth	6,38N,15W	Camden			x	x			B			
Trib. to Horse Cr.	C	2.0	Mouth	29,32N,28W	Dade			x	x			B			
Trib. to Howell Cr.	C	1.4	Mouth	12,23N,7W	Howell			x	x			B			
Trib. to Huzzah Cr.	C	1.6	Mouth	29,37N,2W	Crawford			x	x			B			
Trib. to Huzzah Cr.	C	1.2	Mouth	26,38N,3W	Crawford			x	x			B			
Trib. to Huzzah Cr.	C	1.2	Mouth	17,35N,2W	Crawford			x	x			B			
Trib. to Huzzah Cr.	C	1.0	Mouth	4,35N,2W	Crawford			x	x			B			
Trib. to Indian Cr.	C	0.6	Mouth	6,40N,1E	Franklin			x	x			B			
Trib. to Indian Cr.	C	2.5	Mouth	15,40N,1W	Washington			x	x			B			
[Trib. to Indian Cr.]	C	1.1	27,35N,4E	27,35N,04E	St. Francois			x	x			B			
White Cr.															
Trib. to Indian Cr.	C	0.3	Mouth	[07,35N,01W]	Washington			x	x			[B]	x		
				7,35N,1W											
[Trib. to Indian Cr.]	P	0.9	Mouth	27,35N,4E	St. Francois			x	x			B			
White Cr.															
Trib. to Indian Cr.	P	0.1	Mouth	35,42N,21W	Benton			x	x			B			
Trib. to Indian Cr.	C	1.9	Mouth	34,42N,20W	Benton			x	x			B			
Trib. to Indian Cr.	C	0.2	Mouth	[12,40N,01W]	Franklin			x	x			B			
				12,40N,1W											
Trib. to Indian Cr.	C	0.9	Mouth	21,40,9W	Maries			x	x			B			
Trib. to Indian Cr.	C	0.4	Mouth	32,38N,03W	Washington			x	x			B			
Trib. to James Cr.	C	1.0	Mouth	22,35N,3W	Crawford			x	x			B			
Trib. to Jenkins Cr.	C	1.8	[7,27N,29W]	[20,27N,29W]	Jasper	Newton		x	x			B			
			7,27N,30W	20,27N,30W											
Trib. to Joachim Cr.	C	1.0	Mouth	10,39N,4E	Jefferson			x	x			B			
Trib. to Joachim Cr.	P	1.7	Mouth	36,39N,4E	Jefferson			x	x			A			
Trib. to Joachim Cr.	C	2.3	Mouth	13,40N,4E	Jefferson			x	x			B			
Trib. to Johns Cr.	C	1.0	Mouth	23,36N,1W	Washington			x	x			B			
Trib. to Kinsey Cr.	C	0.3	Mouth	33,39N,7E	Ste. Genevieve			x	x			B			
Trib. to Knobby Cr.	P	[0.9] 1.4	Mouth	[35,40N,20W]	Benton			x	x			B			
				36,40N,20W											
Trib. to Kriete Cr.	C	1.0	Mouth	14,42N,4W	Franklin			x	x			B			
Trib. to L. Apple Cr.	C	0.5	Mouth	18,33N,12E	Cape Girardeau			x	x			B			
Trib. to L. Beaver Cr.	C	2.3	Mouth	15,37N,8W	Phelps			x	x				x		
Trib. to L. Berger Cr.	C	1.0	Mouth	4,45N,4W	Groesbeade			x	x			B			
Trib. to L. Boeuf Cr.	C	0.3	Mouth	[15,44N,2W]	Franklin			x	x			B			
				14,44N,2W											
Trib. to L. Boeuf Cr.	C	1.2	Mouth	11,44N,2W	Franklin			x	x			B			
Trib. to L. Bourbeuse R.	C	1.2	Mouth	4,39N,4W	Crawford			x	x			B			
Trib. to L. Bourbeuse R.	C	2.0	Mouth	4,39N,4W	Crawford			x	x			[B]	x		
Trib. to L. Bourbeuse R.	C	0.1	Mouth	04,39N,07W	Maries			x	x			B			
Trib. to L. Bourbeuse R.	P	1.4	Mouth	02,39N,04W	Crawford			x	x			B			
Trib. to L. Clear Cr.	C	1.0	Mouth	2,36N,28W	St. Clair			x	x			B			
Trib. to L. Deer Cr.	C	0.4	Mouth	24,39N,21W	Benton			x	x			B			
Trib. to L. Dry Wood Cr.	C	1.3	Mouth	02,34N,32W	Vernon			x	x			B			
Trib. to L. Finley Cr.	P	2.0	Mouth	7,28N,17W	Webster			x	x			B			

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Trib. to L. Indian Cr.	C	1.0	Mouth	26,40N,1E	Washington			x	x			B			
Trib. to L. Maries Cr.	C	1.5	Mouth	30,42N,10W	Osage			x	x			B			
<b>Trib. to L. Maries R.</b>	<b>C</b>	<b>0.6</b>	<b>Mouth</b>	<b>29,39N,11W</b>	<b>Maries</b>			<b>x</b>	<b>x</b>			<b>B</b>	<b>x</b>		
Trib. to L. Maries R.	C	0.5	Mouth	3,40N,10W	Maries			x	x			B			
Trib. to L. Maries R.	C	0.9	Mouth	[11,39N,11W]	Maries			x	x			B			
				<b>1,39N,11W</b>											
Trib. to L. Maries R.	C	1.8	Mouth	09,40N,10W	Maries			x	x			B			
Trib. to L. Maries R.	C	0.1	Mouth	09,38N,11W	Maries			x	x			B			
Trib. to L. Mill Cr.	C	0.6	Mouth	19,38N,21W	Hickory			x	x			B			
Trib. to L. Moniteau Cr.	C	3.0	Mouth	11,45N,15W	Moniteau			x	x			B			
Trib. to L. Muddy Cr.	C	2.9	Mouth	[06,46N,22W]	Pettis			x	x			B			
				<b>6,46N,22W</b>											
Trib. to L. Muddy Cr.	C	2.5	Mouth	04,46N,22W	Pettis			x	x			B			
Trib. to L. Muddy Cr.	C	1.0	Mouth	14,46N,22W	Pettis			x	x			B			
Trib. to L. N. Fk. Spring R.	C	1.2	Mouth	29,31N,32W	Barton			x	x			B			
Trib. to L. Rocky Cr.	C	1.0	Mouth	1,28N,3W	Shannon			x	x			B			
Trib. to L. Sandy Cr.	C	2.1	Mouth	Sur 1686,51N,1W	Lincoln			x	x			B			
Trib. to L. Splice Cr.	C	1.0	Mouth	19,47N,14W	Moniteau			x	x			B			
Trib. to L. Tavern Cr.	C	1.1	Mouth	27,40N,11W	Maries			x	x			B			
Trib. to L. Tavern Cr.	C	1.3	Mouth	15,40N,11W	Maries			x	x			B			
Trib. to L. Tavern Cr.	C	1.2	Mouth	22,40N,11W	Maries			x	x			B			
Trib. to L. Tebo Cr.	C	1.5	Mouth	30,42N,22W	Benton			x	x			B			
Trib. to L. Tebo Cr.	C	0.9	Mouth	21,42N,22W	Benton			x	x			B			
Trib. to L. Turkey Cr.	C	1.4	Mouth	3,39N,22W	Benton			x	x			B			
Trib. to L. Weaubleau Cr.	C	0.5	Mouth	12,36N,23W	Hickory			x	x			B			
<b>Trib. to L. Whitewater Cr.</b>	<b>P</b>	<b>1.2</b>	<b>Mouth</b>	<b>16,33N,9E</b>	<b>Bollinger</b>			<b>x</b>	<b>x</b>			<b>A</b>			
Trib. to La Barque Cr.	P	1.0	Mouth	4,42N,3E	Jefferson			x	x			B			
Trib. to Labadie Cr.	P	1.6	Mouth	6,43N,2E	Franklin			x	x			B			
Trib. to Labadie Cr.	C	0.5	Mouth	1,43N,1E	Franklin			x	x			[B]	x		
Trib. to Labadie Cr.	C	1.0	Mouth	32,44N,2E	Franklin			x	x			B			
Trib. to Lake Cr.	C	1.2	Mouth	17,43N,20W	Benton			x	x			B			
Trib. to Lake Cr.	C	0.6	Mouth	[09,43N,20W]	Benton			x	x			B			
				<b>9,43N,20W</b>											
Trib. to Lake Cr.	C	4.0	Mouth	02,43N,20W	Pettis	Benton		x	x			B			
Trib. to Lake Niangua	C	0.7	Mouth	19,37N,17W	Camden			x	x			B			
[Trib. to Lake of Ozarks]	C	1.0	Mouth	17,40N,19W	Camden			x	x			B			
<b>Lick Cr.</b>															
Trib. to Lake of Ozarks	C	0.8	Mouth	5,39N,19W	Camden			x	x			B			
[Trib. to Lake of Ozarks]	C	0.7	Mouth	11,39N,19W	Camden			x	x			B			
<b>Pearson Br.</b>															
Trib. to Lick Cr.	C	1.2	Mouth	34,39N,4W	Crawford			x	x			B			
Trib. to Lick Log Cr.	C	1.0	Mouth	33,29N,8E	Bollinger			x	x			B			
Trib. to Lindley Cr.	C	3.0	Mouth	34,35N,20W	Dallas			x	x			B			
Trib. to Little Cr.	C	1.0	Mouth	18,24N,15W	Ozark			x	x			B			
Trib. to Lk. Wappapello	P	0.5	Mouth	8,27N,7E	Wayne			x	x			B			
Trib. to Lk. Wappapello	C	0.5	8,27N,7E	9,27N,7E	Wayne			x	x			B			
Trib. to Logan Cr.	C	1.0	Mouth	28,44N,13W	Cole			x	x			B			
Trib. to Long Br.	C	0.4	Mouth	07,45N,23W	Pettis			x	x			B			

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Trib. to Lost Cr.	C	1.0	Mouth	18,37N,1E	Washington			x	x			B			
Trib. to Lost Cr.	C	1.0	Mouth	21,37N,1W	Washington			x	x			B			
Trib. to Loutre R.	C	4.0	Mouth	20,50N,7W	Audrain			x	x			B			
Trib. to Luther Br.	C	1.4	Mouth	30,38N,6W	Phelps			x	x			B			
Trib. to M. Fabius R.	C	1.1	Mouth	6,60N,7W	Lewis			x	x			B			
Trib. to Macks Cr.	C	1.0	Mouth	18,37N,18W	Camden			x	x			B			
Trib. to Macks Cr.	C	1.0	Mouth	6,37N,18W	Camden			x	x			B			
Trib. to Marble Cr.	C	0.5	Mouth	18,32N,5E	Madison			x	x			B			
Trib. to Marble Cr.	C	1.5	Mouth	22,33N,4E	Iron			x	x			B			
Trib. to Maries R.	C	0.4	Mouth	18,38N,10W	Maries			x	x			B			
Trib. to Maries R.	C	0.7	Mouth	14,38N,11W	Maries			x	x			B			
Trib. to Maries R.	C	1.7	Mouth	9,39N,10W	Maries			x	x			B			
Trib. to Maries R.	C	0.5	Mouth	[06,39N,10W] 6,39N,10W	Maries			x	x			B			
Trib. to Maries R.	C	2.5	Mouth	21,42N,10W	Osage			x	x			B			
Trib. to Massey Cr.	C	3.3	Mouth	33,45N,33W	Cass			x	x			B	x		
Trib. to Maupin Br.	P	2.0	Mouth	26,47N,14W	Moniteau			x	x			B			
Trib. to Meramec R.	C	0.8	Mouth	29,38N,5W	Crawford			x	x			B			
Trib. to Meramec R.	C	1.4	Mouth	2,36N,5W	Crawford			x	x			B			
Trib. to Meramec R.	C	1.3	Mouth	23,36N,5W	Crawford			x	x			B			
Trib. to Meramec R.	C	1.5	Mouth	27,36N,5W	Crawford			x	x			B			
Trib. to Meramec R.	C	2.0	Mouth	30,36N,4W	Crawford			x	x			B			
Trib. to Meramec R.	C	1.0	Mouth	26,37N,5W	Crawford			x	x			B			
Trib. to Meramec R.	C	1.2	Mouth	8,37N,5W	Crawford			x	x			B			
Trib. to Meramec R.	C	2.4	Mouth	2,37N,5W	Crawford			x	x			B			
Trib. to Middle Big Cr.	C	3.6	Mouth	Lake Harrisonville	Cass			x	x			B			
Trib. to Mill Cr.	C	1.8	Mouth	14,37N,15W	Camden			x	x			B			
Trib. to Mill Cr.	C	1.0	Mouth	33,51N,1W	Lincoln			x	x			B			
Trib. to Mill Cr.	C	1.8	Mouth	13,66N,38W	Nodaway			x	x			B			
Trib. to Mill Cr.	C	0.3	Mouth	14,37N,21W	Hickory			x	x			B			
Trib. to Mill Cr.	C	0.6	Mouth	9,37N,21W	Hickory			x	x			B			
[Trib. to Mill Cr.]	C	[0.1]/0.1	[Mouth]	[10,40N,08W]	Maries			x	x			B			
Mill Spring Cr.			3,40N,8W	3,40N,8W											
Trib. to Mill Cr.	C	2.2	Mouth	LG 1086,51N,1W	Lincoln			x	x			B			
Trib. to Mine a Breton Cr.	C	[0.4]/1.0	Mouth	24,37N,2E	Washington			x	x			B			
Trib. to Mineral Br.	C	0.5	Mouth	16,44N,15W	Moniteau			x	x			B			
Trib. to Mineral Cr.	C	1.0	Mouth	18,44N,25W	Johnson			x	x			B			
Trib. to Mineral Fk.	C	2.0	Mouth	33,39N,3E	Washington			x	x			B			
Trib. to Missouri R.	PI	3.0	Mouth	21,44N,1E	St. Charles			x	x			B			
Trib. to Missouri R.	C	3.1	Mouth	07,44N,01W	Franklin			x	x			B			
Trib. to Missouri R.	C	5.3	Mouth	14,51N,23W	Saline			x	x			B			
Trib. to Moreau R.	C	0.5	Mouth	[06,43N,12W] 6,43N,12W	Cole			x	x				x		
Trib. to Moss Cr.	P	0.5	Mouth	12,52N,24W	Carroll			x	x			B			
Trib. to Mud Cr.	C	0.8	Mouth	12,55N,26W	Caldwell			x	x			B			
Trib. to Mud Cr.	C	2.0	Mouth	24,55N,26W	Caldwell			x	x			B			
Trib. to Mud Cr.	C	1.0	Mouth	12,55N,26W	Caldwell			x	x			B			
Trib. to Muddy Cr.	C	1.7	Mouth	10,46N,21W	Pettis			x	x			B	x		

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Trib. to Muddy Cr.	C	1.9	Mouth	06,45N,22W	Pettis			x	x			B			
Trib. to Muddy Cr.	C	1.1	Mouth	32,46N,22W	Pettis			x	x			B			
Trib. to Muddy Cr.	C	1.0	Mouth	/04,45N,22W/	Pettis			x	x			B			
				4,45N,22W											
Trib. to Muddy Cr.	C	2.5	Mouth	24,46N,23W	Pettis			x	x			[B]	x		
Trib. to Muddy Cr.	C	2.0	Mouth	29,60N,22W	Grundy			x	x			B			
Trib. to Murphy Cr.	C	0.5	Mouth	4,36N,14W	Camden			x	x			B			
Trib. to Murphy Cr.	C	1.0	Mouth	34,37N,14W	Camden			x	x			B			
Trib. To N. Br. Wilsons Cr.	C	1.3	16,29N,22W	10,29N,22W	Greene			x	x			B			
Trib. to N. Fabius R.	C	2.0	Mouth	18,32N,8W	Lewis			x	x			B			
Trib. to N. Fabius R.	P	0.9	Mouth	14,65N,12W	Scotland			x	x			B			
Trib. to N. Fabius R.	P	0.8	14,65N,12W	15,65N,12W	Scotland			x	x			B			
Trib. to N. Fabius R.	P	1.1	Mouth	20,66N,13W	Schuyler			x	x			B			
Trib. to N. Fk. Cuivre R.	C	2.0	Mouth	25,51N,2W	Lincoln			x	x			B			
Trib. to N. Fk. M. Fabius R.	C	3.1	Mouth	14,66N,15W	Schuyler			x	x			B			
Trib. to N. Fk. S. Fabius R.	C	0.4	Mouth	7,62N,11W	Knox			x	x			B			
Trib. to N. Fk. S. Fabius R.	C	1.0	Mouth	12,62N,12W	Knox			x	x			B			
Trib. to N. Fk. Salt R.	C	2.7	Mouth	4,64N,15W	Adair	Schuyler		x	x			B			
Trib. to N. Fk. Salt R.	C	1.2	Mouth	20,57N,10W	Shelby			x	x			B			
Trib. to N. Fk. Spring R.	C	5.3	Mouth	31,33N,30W	Barton			x	x			B			
Trib. to N. Fk. White R.	C	1.2	Mouth	34,23N,12W	Ozark			x	x			B			
Trib. to N. Indian Cr.	P	1.3	Mouth	19,24N,30W	Newton			x	x			B			
Trib. to N. Moreau Cr.	C	0.8	Mouth	23,44N,13W	Cole			x	x			B			
Trib. to N. Moreau Cr.	C	0.5	Mouth	8,44N,13W	Cole			x	x			B			
Trib. to N. Moreau Cr.	C	2.4	Mouth	33,45N,15W	Moniteau			x	x						
Trib. to N. Moreau Cr.	C	0.5	Mouth	4,44N,15W	Moniteau			x	x			B			
Trib. to N. Moreau Cr.	C	2.0	Mouth	2,44N,16W	Moniteau			x	x			B			
Trib. to N. Moreau Cr.	C	2.0	Mouth	12,44N,16W	Moniteau			x	x			B			
Trib. to N. Moreau Cr.	C	2.0	Mouth	18,44N,15W	Moniteau			x	x			B			
Trib. to Niangua R.	C	1.2	Mouth	17,37N,17W	Camden			x	x			B			
Trib. to Nichols Cr.	C	1.3	Mouth	29,61N,37W	Holt			x	x			B			
Trib. to Nichols Cr.	P	1.4	Mouth	19,53N,2W	Pike			x	x			B			
Trib. To Nodaway R.	C	1.0	Mouth	13,60N,37W	Andrew			x	x			B			
Trib. to North Cut Ditch	C	2.0	Mouth	36,29N,14E	Scott		x	x	x			B			
Trib. to North Cut Ditch	C	4.0	Mouth	34,27N,14E	Scott		x	x	x			B			
Trib. to Old Town Br.	C	1.7	Mouth	01,36N,31W	Vernon			x	x			B			
Trib. to Omele Cr.	C	1.3	Mouth	16,35N,12E	Perry			x	x			B			
[Trib. to Osage Fk.]	P	3.0	Mouth	29,30N,17W	Webster			x	x			B			
Trib. to Osage Fk. Gasconade R.															
Trib. to Osage R.	C	2.0	Mouth	9,43N,10W	Cole			x	x			B			
Trib. to Osage R.	C	0.8	Mouth	9,42N,12W	Cole			x	x			B			
Trib. to Panther Cr.	C	2.4	Mouth	23,57N,26W	Caldwell			x	x			B			
Trib. to Pena Cr.	C	1.0	19,55N,3W	30,55N,3W	Pike			x	x			B			
Trib. to Perche Cr.	C	2.0	Mouth	5,47N,13W	Boone			x	x				x		
Trib. to Perkins Cr.	C	2.0	Mouth	25,30N,8E	Bollinger			x	x			B			

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Trib. to Pierce Cr.	C	0.9	Mouth	31,41N,02E	Franklin			x	x			B			
Trib. to Pierce Cr.	C	1.0	Mouth	[06,40N,02E]	Franklin			x	x			B			
				6,40N,2E											
Trib. to Pippin Br.	C	1.5	Mouth	29,37N,20W	Hickory			x	x			B			
Trib. to Pippin Br.	C	0.5	Mouth	26,37N,20W	Hickory			x	x			B			
Trib. to Platin Cr.	P	[1.0]/1.3	Mouth	13,39N,5E	Jefferson			x	x			B			
Trib. to Pond Cr.	C	1.9	[35,38N,3E]	11,37N,3E	Washington			x	x			B			
			Mouth												
Trib. to Pond Cr.	C	1.0	Mouth	15,29N,8E	Bollinger			x	x			B			
Trib. to Possum Hollow	P	0.5	Mouth	22,27N,7E	Wayne			x	x			B			
Trib. to Possum Hollow	C	0.5	22,27N,7E	15,27N,7E	Wayne			x	x			B			
Trib. to Prairie Cr.	C	1.0	Mouth	24,52N,35W	Platte			x	x			B			
Trib. to Province Br.	C	1.0	Mouth	3,29N,25W	Lawrence			x	x			B			
Trib. to Pratt Cr.	C	1.0	Mouth	21,38N,5W	Crawford			x	x			B			
Trib. to Pruet Cr.	P	0.1	LG 929,47N,2E	LG 929,47N,2E	St. Charles			x	x			B			
Trib. to Purcheon Cr.	C	1.5	Mouth	30,44N,5W	Gasconade			x	x			B			
Trib. to Pyan Hollow	C	1.5	Mouth	24,36N,3W	Crawford			x	x			B			
Trib. to Raccoon Cr.	C	1.0	Mouth	9,61N,25W	Grundy			x	x			B			
Trib. to Red Oak Cr.	P	0.5	Mouth	35,42N,05W	Gasconade			x	x			B			
Trib. to Red Oak Cr.	C	1.9	35,42N,05W	27,42N,05W	Gasconade			x	x					x	
Trib. to Rings Cr.	C	1.0	Mouth	14,29N,4E	Wayne			x	x			B			
Trib. to Rings Cr.	C	0.5	Mouth	26,29N,4E	Wayne			x	x			B			
Trib. to Roark Br.	C	1.6	Mouth	3,43N,14W	Cole			x	x			B		x	
Trib. to Rockhouse Cr.	C	3.0	Mouth	34,23N,26W	Barry			x	x			B		x	
Trib. to S. Fk. Apple Cr.	C	0.8	Mouth	33,34N,10E	Perry			x	x			B			
Trib. to S. Fk. Blackwater R.	C	1.3	Mouth	3,46N,23W	Pettis			x	x			B			
Trib. to S. Fk. Blackwater R.	C	3.9	Mouth	18,46N,28W	Johnson			x	x			B			
Trib. to S. Fk. Brush Cr.	C	1.7	Mouth	33,35N,24W	Polk			x	x			B			
Trib. to S. Fk. N. Fabius R.	C	4.1	Mouth	30,67N,14W	Schuyler			x	x			B			
Trib. to S. Fk. Saline Cr.	P	2.0	Mouth	3,34N,9E	Perry			x	x			B			
Trib. to S. Fk. Saline Cr.	C	0.7	Mouth	1,34N,8E	Ste. Genevieve			x	x			B			
Trib. to S. Fk. Salt R.	C	0.5	Mouth	35,52N,9W	Audrain			x	x			B			
Trib. to S. Fk. Salt R.	P	0.6	Mouth	36,51N,9W	Audrain			x	x			B			
Trib. to S. Fk. Spring R.	P	1.0	Mouth	34,22N,8W	Howell			x	x			B			
Trib. to S. Fk. Wenableau Cr.	C	7.0	Mouth	25,36N,24W	St. Clair	Hickory		x	x			[B]		x	
Trib. to S. Flat Cr.	C	2.4	Mouth	24,43N,22W	Benton			x	x			[B]		x	
Trib. to S. Flat Cr.	C	1.1	Mouth	[03,43N,21W]	Pettis			x	x			B			
				3,43N,21W											
Trib. to S. Moreau Cr.	C	1.5	Mouth	28,43N,15W	Moniteau			x	x			B			
Trib. to S. Moreau Cr.	P	0.8	Mouth	31,43N,15W	Moniteau			x	x			B			
Trib. to S. Moreau Cr.	C	1.5	31,43N,15W	25,43N,16W	Moniteau			x	x			B			
Trib. to S. Moreau Cr.	C	0.7	Mouth	25,43N,14W	Cole			x	x			B			
Trib. to S. Moreau Cr.	C	0.5	Mouth	24,43N,13W	Cole			x	x			B			
Trib. to S. Moreau Cr.	C	1.5	Mouth	29,42N,15W	Miller			x	x					x	
Trib. to S. Spencer Cr.	C	1.3	Mouth	12,53N,5W	Pike			x	x					x	
Trib. to Saline Cr.	C	0.6	Mouth	LG 1331,43N,5E	Jefferson			x	x			B			

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Trib. to Salt Cr.	C	1.3	Mouth	17,38N,26W	St. Clair		x	x				B			
Trib. to Sandy Cr.	P	0.1	Mouth	33,42N,04E	Jefferson		x	x				B			
Trib. to Sandy Cr.	P	0.2	Mouth	32,42N,04E	Jefferson		x	x				B			
Trib. to Sandy Cr.	C	0.9	Mouth	LG 1976,41N,4E	Jefferson		x	x				B			
Trib. to Schawnee Spr. Br.	C	1.2	Mouth	33,35N,11E	Perry		x	x				B			
Trib. to Sellars Cr.	C	1.0	Mouth	6,36N,14W	Camden		x	x				B			
Trib. to Sharpsburg Br.	C	1.1	Mouth	13,56N,8W	Marion	Monroe	x	x				B			
Trib. to Shaver Cr.	C	0.9	Mouth	28,46N,20W	Pettis		x	x				B			
Trib. to Shaver Cr.	C	1.3	Mouth	14,46N,20W	Pettis		x	x				B			
Trib. to Shaver Cr.	C	1.1	Mouth	06,45N,20W	Pettis		x	x				B			
Trib. to Shaw Br.	C	0.2	Mouth	LG 3272,36N,5E	St. Francois		x	x				B			
[Trib. to Shabboeth Cr.]	C	1.3	Mouth	9,38N,3E	Washington		x	x					x		
Trib. to Shabboeth Br.															
Trib. to Shoal Cr.	C	1.0	Mouth	34,37N,2W	Crawford		x	x				B			
Trib. to Shoal Cr.	C	0.5	Mouth	34,37N,2W	Crawford		x	x				B			
Trib. to Shoal Cr.	P	1.0	Mouth	10,26N,32W	Newton		x	x				B			
Trib. to Silver Fk.	C	1.5	Mouth	19,51N,11W	Boone		x	x				B			
Trib. to Silver Fk.	C	1.0	Mouth	28,50N,13W	Boone		x	x				B			
Trib. to Skullbones Cr.	C	0.2	Mouth	35,42N,3E	Jefferson		x	x				B			
Trib. to Spring Cr.	P	1.0	Mouth	18,26N,23W	Stone		x	x				B			
Trib. to Spring Cr.	C	1.1	Mouth	14,38N,08W	Phelps		x	x				B			
Trib. to Spring Cr.	P	0.8	[14,38N,08W]	[10,38N,08W]	Phelps		x	x				B			
Trib. to Spring Cr.	C	0.7	Mouth	26,35N,10W	Phelps		x	x				B			
Trib. to Spring Cr.	C	0.2	Mouth	17,34N,5E	Dent		x	x				B			
Trib. to Spring Fk.	C	2.5	Mouth	02,43N,21W	Pettis	Benton	x	x				B			
Trib. to Spring Fk.	C	0.7	Mouth	36,44N,21W	Pettis		x	x				B			
Trib. to Spring R.	C	5.0	Mouth	23,29N,33W	Jasper		x	x				B			
Trib. to Spring R.	C	2.7	Mouth	1,28N,28W	Lawrence		x	x				B			
Trib. to Spring R.	C	1.0	16,28N,28W	15,28N,28W	Lawrence		x	x				B			
Trib. to Spring R.	P	2.8	Mouth	5,28N,28W	Lawrence		x	x				B			
Trib. to St. Francis R.	C	1.0	Mouth	9,35N,4E	St. Francois		x	x				B			
Trib. to St. Francis R.	C	1.0	Mouth	33,31N,5E	Madison		x	x				B			
Trib. to St. John's Cr.	C	1.5	Mouth	18,43N,2W	Franklin		x	x				B			
Trib. to St. John's Cr.	C	2.9	Mouth	7,44N,1W	Franklin		x	x					x		
Trib. to Stahl Cr.	C	2.6	Mouth	22,29N,27W	Lawrence		x	x				B			
Trib. to Starks Cr.	C	0.8	Mouth	19,37N,20W	Hickory		x	x				B			
Trib. to Starks Cr.	C	1.1	Mouth	29,38N,20W	Hickory		x	x				B			
Trib. to Starks Cr.	C	0.5	Mouth	18,37N,20W	Hickory		x	x				B			
Trib. to Starks Cr.	C	1.9	Mouth	18,38N,20W	Hickory		x	x				B			
Trib. to Starks Cr.	C	1.0	Mouth	02,37N,21W	Hickory		x	x				B			
Trib. to Stockton Br.	C	2.0	Mouth	6,34N,26W	Cedar		x	x				B			
Trib. to Stouts Cr.	C	0.5	Mouth	6,33N,5E	Madison		x	x				B			
Trib. to Stouts Cr.	C	1.0	Mouth	6,33N,5E	Madison		x	x				B			
Trib. to Stouts Cr.	C	1.3	Mouth	36,34N,03E	Iron		x	x				B			
Trib. to Strobel Br.	C	0.5	Mouth	1,44N,14W	Cole		x	x				B			
Trib. to Strobel Br.	C	0.5	Mouth	36,45N,14W	Cole		x	x				B	x		

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Trib. to Sweetwater Br.	C	1.0	Mouth	19,34N,7E	Madison		x	x				B			
Trib. to Tater Hill Cr.	C	2.0	Mouth	22,55N,24W	Carroll		x	x				B			
Trib. to Tavern Cr.	C	0.1	Mouth	[01,44N,02E]	Franklin		x	x				B			
				1,44N,2E											
Trib. to Third Cr.	C	1.0	Mouth	5,42N,6W	Gasconade		x	x				B			
Trib. to Third Cr.	C	0.7	Mouth	6,42N,6W	Gasconade		x	x				B			
Trib. to Thomas Cr.	C	0.5	Mouth	26,36N,20W	Dallas		x	x				B			
Trib. to Titus Cr.	C	1.8	Mouth	14,60N,14W	Macon		x	x				B			
Trib. to Trib. M. Fk. Tebo Cr.	C	1.3	Mouth	36,44N,25W	Henry		x	x				B			
Trib. to Trib. to Wolf Cr.	C	0.8	Mouth	32,36N,6E	St. Francois		x	x				B			
Trib. To trib. to Flat Cr.	C	2.1	Mouth	13,45N,20W	Pettis		x	x				B			
Trib. to trib. to Hentis Cr.	C	1.5	Mouth	27,47N,22W	Pettis		x	x				B			
Trib. to Trib. to N. Fabius R.	C	0.4	Mouth	17,66N,13W	Schuyler		x	x				B			
Trib. to Trib. to N. Fk. M. Fabius R.	C	0.4	Mouth	23,66N,15W	Schuyler		x	x				B			
Trib. to Trib. to N. Fk. M. Fabius R.	C	0.4	Mouth	14,66N,15W	Schuyler		x	x				B			
Trib. to Trib. to N. Fk. Salt R.	C	0.5	Mouth	4,64N,15W	Schuyler		x	x				B			
Trib. to Trib. to S. Fk. Salt R.	C	1.3	36,51N,9W	35,51N,9W	Audrain		x	x				B			
Trib. to Trib. to S. Fk. Salt R.	C	0.3	Mouth	36,51N,9W	Audrain		x	x				B			
Trib. to Trib. to Sharpsburg Br.	C	0.2	Mouth	13,56N,8W	Mourne		x	x				B			
Trib. to Trib. to Titus Cr.	C	0.3	Mouth	14,60N,14W	Macon		x	x				B			
Trib. to Trib. to Weaubleau Cr.	C	0.8	Mouth	15,36N,23W	Hickory		x	x				B			
Trib. to Troublesome Cr.	C	0.5	Mouth	16,61N,9W	Lewis		x	x				B			
Trib. to Troublesome Cr.	C	1.2	Mouth	16,61N,9W	Lewis		x	x				B			
Trib. to Turkey Cr.	C	2.2	Mouth	2,31N,24W	Polk		x	x				B			
Trib. to Turkey Cr.	C	0.3	Mouth	09,38N,21W	Hickory		x	x				B			
Trib. to Turkey Cr.	C	2.4	Mouth	14,38N,21W	Hickory		x	x				B			
Trib. to Turkey Cr.	C	1.0	Mouth	23,38N,21W	Hickory		x	x				B			
Trib. to Turkey Cr.	C	0.5	Mouth	20,47N,21W	Pettis		x	x				B			
Trib. to Turkey Cr.	C	1.7	Mouth	33,39N,21W	Benton		x	x				B			
Trib. to Turkey Cr.	C	1.0	Mouth	29,57N,26W	Caldwell		x	x				B			
Trib. to Turkey Cr.	C	0.5	Mouth	17,59N,16W	Macon		x	x				B			
Trib. to Tumbuck Cr.	P	1.0	Mouth	24,29N,26W	Lawrence		x	x				B			
Trib. to Twelve Mile Cr.	C	1.0	Mouth	6,31N,7E	Madison		x	x				B			
Trib. to Unnamed trib to Atwell Cr.	C	0.6	Mouth	07,38N,11W	Maries		x	x				B			
Trib. to W. Fk. Benton Cr	C	0.4	Mouth	24,36N,6W	Phelps		x	x				B			
Trib. to W. Fk. Clear Cr.	C	0.8	Mouth	35,36N,30W	Vernon		x	x				B			
Trib. to W. Fk. Finney Cr.	C	0.8	Mouth	7,49N,21W	Saline		x	x				B			
Trib. to W. Fk. Lost Cr.	C	0.5	Mouth	13,28N,6E	Wayne		x	x				B			
Trib. to W. Fk. Lost Cr.	C	2.8	Mouth	[Maysville Lake]	DeKalb		x	x				B	x		
				4,58N,31W											
Trib. to W. Fk. Lost Cr.	C	2.6	Mouth	9,58N,31W	DeKalb		x	x				B			
Trib. to W. Fk. Niangua R.	P	1.5	Mouth	19,31N,18W	Webster		x	x				B			
Trib. to W. Fk. Postoak Cr.	C	1.4	Mouth	36,45N,27W	Johnson		x	x				B			

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Trib. to W. Fk. Roubidoux Cr.	C	2.2	Mouth	33,31N,11W	Texas			x	x				B		
Trib. to W. Mill Cr.	C	0.8	Mouth	19,37N,3E	Washington			x	x						
Trib. to W. Muddy Cr.	P	0.5	Mouth	31,64N,24W	Mercer			x	x				B		
Trib. to Wade Cr.	C	2.0	Mouth	33,44N,25W	Henry			x	x				B		
Trib. to Wallace Cr.	P	1.8	Mouth	07,40N,06W	Gasconade			x	x				B		
Trib. to Wallen Cr.	P	1.0	Mouth	4,36N,3E	Washington			x	x				B		
Trib. to Wallen Cr.	C	1.5	4,36N,3E	32,37N,3E	Washington			x	x				B		
Trib. to Watery Fk.	C	1.0	Mouth	5,34N,4W	Dent			x	x				B		
Trib. to Weaubleau Cr.	C	0.5	Mouth	3,35N,23W	Hickory			x	x				B		
Trib. to Weaubleau Cr.	C	1.3	Mouth	[02,35N,23W]/ 2,35N,23W	Hickory			x	x				B		
Trib. to Weaubleau Cr.	C	1.3	Mouth	26,36N,23W	Hickory			x	x				B		
Trib. to Weaubleau Cr.	C	1.5	Mouth	23,36N,23W	Hickory			x	x				B		
Trib. to Weaubleau Cr.	C	0.8	Mouth	19,36N,23W	Hickory			x	x				B		
Trib. to Weidensaul Holl.	C	1.0	Mouth	35,23N,13W	Ozark			x	x				B		
Trib. to White Oak Cr.	C	0.5	Mouth	25,42N,13W	Cole			x	x				B		
Trib. to White Oak Cr.	C	6.3	Mouth	24,29N,28W	Lawrence			x	x				B		
Trib. to Whitewater R.	C	1.7	Mouth	3,30N,11E	Cape Girardeau			x	x				B		
Trib. to Whittenburg Cr.	C	1.0	Mouth	12,37N,4W	Crawford			x	x				B		
Trib. to Wildcat Cr.	C	2.0	Mouth	30,63N,32W	Gentry			x	x				B		
Trib. to Wildcat Cr.	C	2.0	Mouth	32,63N,33W	Nodaway			x	x						
Trib. to Williams Cr.	P	1.0	Mouth	[Sur 256,30N,13E]/ LG 236,30N,13E	Cape Girardeau			x	x				B		
Trib. to Willow Fk.	C	0.5	Mouth	27,45N,17W	Moniteau			x	x						
Trib. to Wolf Cr.	P	1.1	Mouth	32,36N,6E	St. Francois			x	x				B		
Trib. to Wolf Cr.	C	1.5	32,36N,6E	Sur 349,36N,6E	St. Francois			x	x				B		
Trib. to Workman Cr.	P	0.5	Mouth	13,45N,13W	Cole			x	x				B		
Trib. to Workman Cr.	C	0.8	Mouth	10,28N,22W	Greene			x	x				B		
Trib. to Yadkin Cr.	C	3.7	Mouth	12,37N,5W	Crawford			x	x				B		
Trib. to Yellow Cr.	C	1.0	Mouth	32,38N,26W	St. Clair			x	x				B		
Trinity Hollow	P	1.6	Mouth	13,38N,23W	Benton	Hickory		x	x				B		
Troesser Cr.	C	0.7	Mouth	18,44N,8W	Osage			x	x				B		
Troublesome Cr.	P	4.8	Mouth	15,59N,7W	Marion			x	x				B		x
Troublesome Cr.	C	41.3	15,59N,7W	5,61N,10W	Marion	Knox		x	x				B	x	
Truitt Cr.	P	1.5	Mouth	23,28N,27W	Lawrence			x	x				B		
Truitt Cr.	C	6.4	23,28N,27W	32,29N,26W	Lawrence			x	x						
Tub Cr.	C	1.0	Mouth	31,56N,28W	Caldwell			x	x				B		
Turns Br.	C	2.7	Mouth	33,36N,19W	Dallas			x	x				B		
Tuque Cr.	P	5.4	Mouth	16,45N,1W	Warren			x	x				B		x
Tuque Cr.	C	2.3	16,45N,1W	3,45N,1W	Warren			x	x				B		
Turkey Cr.	P	17.9	Mouth	[05,38N,21W]/ 5,38N,21W	Benton			x	x	x			B		
Turkey Cr.	C	15.9	Mouth	21,35N,25W	St. Clair	Cedar		x	x				A		
Turkey Cr.	P	6.0	Mouth	27,32N,24W	Polk			x	x				B		
Turkey Cr.	C	3.3	Mouth	3,53N,10W	Monroe			x	x				B		
Turkey Cr.	P	2.0	Mouth	32,33N,14E	Cape Girardeau			x	x				B		
Turkey Cr.	C	2.2	32,33N,14E	36,33N,13E	Cape Girardeau			x	x				B		

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Turkey Cr.	C	1.5	Mouth	21,49N,2W	Lincoln			x	x			B	x		
Turkey Cr.	C	1.4	Mouth	[Sur 3022,40N,2E]	Washington			x	x			B			
				LG 3022,40N,2E											
Turkey Cr.	P	2.6	Mouth	16,22N,21W	Taney			x	x		x	B	x		
Turkey Cr.	C	4.0	16,22N,21W	4,21N,21W	Taney			x	x			[B]	x		
Turkey Cr.	C	9.9	Mouth	15,24N,15W	Ozark			x	x			B			
Turkey Cr.	C	2.6	Mouth	22,22N,16W	Ozark			x	x			B			
Turkey Cr.	C	1.5	Mouth	9,26N,15W	Douglas			x	x			B			
Turkey Cr.	C	4.5	Mouth	36,34N,5E	Madison			x	x			B			
Turkey Cr.	C	3.1	Mouth	34,27N,8E	Stoddard			x	x			B	x		
Turkey Cr.	P	7.7	State Line	35,28N,33W	Jasper			x	x			B			
Turkey Cr.	P	6.1	35,28N,33W	9,27N,32W	Jasper			x	x			A			
Turkey Cr.	P	[2.4/3.3	Mouth	[Hwy. 47]	St. Francois			x	x			B			
				LG 467,37N,4E											
Turkey Cr.	P	4.7	Mouth	14,53N,25W	Carroll			x	x			B			
Turkey Cr.	C	3.5	14,53N,25W	34,54N,25W	Carroll			x	x			B			
Turkey Cr.	C	5.8	05,38N,21W	22,38N,21W	Benton	Hickory		x	x			B			
Turkey Cr.	C	1.8	Mouth	26,62N,33W	Gentry			x	x			B			
Turkey Cr.	C	2.5	Mouth	33,57N,26W	Caldwell			x	x			B			
Turkey Cr.	C	14.4	Mouth	Hwy. 36	Chariton	Linn		x	x			B			
Turkey Cr.	C	3.5	Mouth	12,66N,17W	Putnam			x	x			B			
Turkey Cr.	C	2.4	Mouth	17,59N,16W	Macon			x	x			B			
Turkey Cr.	C	3.3	Mouth	3,44N,11W	Callaway			x	x			B	x		
Turkey Cr.	C	6.3	Mouth	14,47N,12W	Boone			x	x			A			
Turkey Cr.	C	2.9	Mouth	20,47N,21W	Pettis			x	x			B			
Turkey Cr.	C	1.7	Mouth	[Sur 3243(3), 53N,5W]	Ralls			x	x			B			
				3,55N,5W											
Turkey Cr.	P	1.0	Mouth	32,34N,8E	Madison			x	x			B			
Turkey Cr.	P	7.3	Mouth	21,30N,7E	Wayne			x	x			B			
Turnback Cr.	P	16.0	Mouth	35,30N,26W	Dade			x	x			A			
Turnback Cr.	P	19.9	35,30N,26W	24,28N,25W	Dade	Lawrence		x	x		x	A	x		
Turnbo Cr.	P	6.8	Mouth	16,30N,18W	Webster			x	x			B			
Turner Cr.	P	4.5	Mouth	33,29N,20W	Greene			x	x			B			
Turtle Spr. Br.	C	3.3	Mouth	23,45N,14W	Moniteau			x	x			B			
Twelve Mile Cr.	P	8.4	Mouth	12,31N,6E	Madison			x	x	x		A			
Twelve Mile Cr.	C	6.8	12,31N,6E	17,32N,7E	Madison			x	x	x		B	x		
Twomile Cr.	C	2.6	Mouth	28,36N,32W	Vernon			x	x			B			
Tyler Br.	C	1.7	36,35N,10E	34,35N,10E	Perry			x	x			[B]	x		
Tyrey Cr.	P	[0.8/3.3	[12,40N,02E]	[11,40N,02E]	Jefferson			x	x			B			
			Mouth	9,40N,2E											
Tyrey Cr.	C	0.2	9,40N,2E	9,40N,2E	Franklin			x	x			B			
Upper Peavine Cr.	C	2.2	Mouth	15,40N,7W	Maries			x	x			B			
Van Meter Ditch	C	4.5	24,52N,22W	4,51N,22W	Saline			x	x			B			
Vance Br.	C	0.5	Mouth	[05,39N,22W]	Benton			x	x			B	x		
				5,39N,22W											
Varney R. Ditch	P	14.0	12,17N,7E	34,19N,9E	Dunklin			x	x			B			
Varney R. Ditch	C	10.0	34,19N,9E	35,20N,9E	Dunklin			x	x			B			
Village Cr.	P	1.9	Mouth	Sur 3323,33N,7E	Madison			x	x			B			

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Village Cr.	C	3.0	Sur 3323,33N,7E	34,34N,7E	Madison			x	x			B			
Virgin Cr.	C	1.2	Mouth	15,29N,9E	Bollinger			x	x			B			
W. Br. Clark Fk.	C	4.0	Mouth	8,47N,16W	Cooper			x	x			B			
W. Br. Crawford Cr.	C	14.7	Mouth	21,47N,30W	Jackson			x	x			B			
W. Br. Mill Cr.	C	1.8	[8,37N,3E]	18,37N,3E	Washington			x	x			[B]	x		
			<b>LG</b>												
			<b>3172,37N,3E</b>												
W. Br. Mill Cr.	C	1.0	18,37N,3E	19,37N,3E	Washington			x	x			B			
W. Cow Cr.	C	4.4	Mouth	11,51N,21W	Saline			x	x			B			
W. Elk Fk.	C	2.5	Mouth	[05,44N,23W]	Pettis			x	x			B			
				<b>5,44N,23W</b>											
W. Fk. Bear Cr.	P	2.8	Mouth	9,29N,6E	Wayne			x	x			B			
W. Fk. Bear Cr.	C	1.0	9,29N,6E	8,29N,6E	Wayne			x	x			B	x		
[W. Fk. Bee Br.]	C	6.5	Mouth	21,56N,17W	Chariton			x	x			B			
<b>W. Bee Br.</b>															
W. Fk. Benton Cr.	C	[2.5] 4.4	Mouth	[7,36N,5W]	Crawford			x	x			B			
				<b>24,36N,6W</b>											
						<b>Phelps</b>									
W. Fk. Big Cr.	C	3.0	Mouth	3,22N,17W	Taney			x	x			B			
W. Fk. Big Cr.	P	18.0	9,63N,28W	34,65N,28W	Harrison			x	x			B			
W. Fk. Big Cr.	C	14.0	34,65N,28W	22,66N,28W	Harrison			x	x			B			
W. Fk. Big Cr.	P	1.4	Mouth	31,31N,7E	Madison			x	x			B			
W. Fk. Big Cr.	C	1.5	31,31N,7E	36,31N,6E	Madison			x	x			B			
W. Fk. Black R.	P	32.3	Mouth	25,33N,03W	Reynolds			x	x	x		A			
W. Fk. Black R.	C	0.5	[25,32N,3W]	[26,32N,3W]	Reynolds			x	x			B			
			<b>25,33N,3W</b>	<b>26,33N,3W</b>											
W. Fk. Bull Cr.	C	4.0	Mouth	8,26N,20W	Christian			x	x			B			
W. Fk. Clear Cr.	C	14.0	Mouth	17,35N,30W	Vernon			x	x			B			
W. Fk. Crooked R.	P	6.6	Mouth	19,52N,27W	Ray		x	x	x			B			
W. Fk. Crooked R.	C	9.8	19,52N,27W	18,52N,28W	Ray			x	x			B			
W. Fk. Cuivre R.	P	42.4	[11,49N,1W]	[Pike Co. Line]	Lincoln	<b>Montgomery</b>		x	x			A			
			<b>Mouth</b>	<b>6,50N,4W</b>											
W. Fk. Cuivre R.	C	23.9	6,50N,4W	14,51N,7W	Pike	<b>Audrain</b>		x	x			B			
W. Fk. Dry Wood Cr.	C	8.1	Mouth	State Line	Vernon			x	x			B			
W. Fk. East Cr.	C	4.8	Mouth	26,46N,33W	Cass			x	x			B	x		
W. Fk. Finney Cr.	C	4.0	[20,49N,21W]	6,49N,21W	Saline			x	x			B			
			<b>Mouth</b>												
W. Fk. Fourche Cr.	P	9.7	Mouth	15,22N,1W	Ripley			x	x	x		B			
W. Fk. Fourche Cr.	C	2.0	15,22N,1W	8,22N,1W	Ripley			x	x	x		B			
W. Fk. Huzzah Cr.	P	5.5	1,34N,3W	22,34N,3W	Dent			x	x			A			
W. Fk. Huzzah Cr.	C	2.0	22,34N,3W	28,34N,3W	Dent			x	x			B			
W. Fk. Jones Cr.	P	0.7	Mouth	16,41N,03E	Jefferson			x	x			B			
W. Fk. Limestone Cr.	C	3.2	Mouth	10,30N,27W	Dade			x	x			B			
[W. Fk. Locust Cr.]	C	17.0	Hwy. 6	33,64N,21W	Sullivan			x	x			B	x		
<b>W. Locust Cr.</b>															
W. Fk. Lost Cr.	P	4.4	Mouth	[25,28N,7E]	Wayne			x	x			B			
				<b>25,28N,6E</b>											
W. Fk. Lost Cr.	C	4.2	25,28N,6E	16,28N,6E	Wayne			x	x			B			
W. Fk. Lost Cr.	C	11.7	Mouth	[27,58N,31W]	DeKalb			x	x			B			
				<b>33,58N,31W</b>											

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W. Fk. Medicine Cr.	C	5.5	Mouth	35,67N,22W	Putnam			x	x			B	x		
W. Fk. Niangua R.	P	7.0	33,32N,18W	33,31N,18W	Webster			x	x			B			
W. Fk. Post Oak Cr.	C	12.8	Mouth	22,45N,27W	Johnson			x	x			B	x		
W. Fk. Roark Cr.	C	3.5	15,23N,22W	7,23N,22W	Taney	Stone	x	x	x			[B]	x		
W. Fk. Roubidoux Cr.	P	3.0	4,31N,11W	17,31N,11W	Texas			x	x			B			
W. Fk. Roubidoux Cr.	C	2.0	17,31N,11W	30,31N,11W	Texas			x	x			B			
W. Fk. Sni-a-bar Cr.	P	9.0	Mouth	Lk Lotawana Dam	Jackson			x	x			B			
W. Fk. Spring Cr.	P	2.5	Mouth	31,22N,8W	Howell			x	x			B			
W. Fk. Spring R.	C	8.7	31,22N,8W	10,22N,9W	Howell			x	x			[B]	x		
W. Fk. Tebo Cr.	C	6.8	Mouth	Hwy. 52	Henry			x	x			B			
W. Fk. Wakenda Cr.	P	3.3	Mouth	6,52N,25W	Carroll			x	x			B			
W. Fk. Wakenda Cr.	C	7.8	6,52N,25W	20,53N,26W	Ray			x	x			B			
W. High Cr.	C	2.8	Mouth	10,66N,41W	Atchison		x	x	x			B			
W. Honey Cr.	C	14.0	Mouth	34,65N,23W	Grundy	Mercer		x	x			B	x		
W. Locust Cr.	P	17.0	Mouth	25,62N,21W	Linn	Sullivan		x	x			B			
W. Locust Cr.	C	12.6	Mouth	7,66N,20W	Putnam			x	x			B	x		
W. Muddy Cr.	P	8.0	Mouth	6,63N,24W	Grundy	Mercer		x	x			B			
W. Muddy Cr.	C	8.5	6,63N,24W	31,65N,24W	Mercer			x	x			B			
W. Piney Cr.	P	13.1	Mouth	33,30N,11W	Texas			x	x			B			
W. Piney Cr.	C	2.0	33,30N,11W	5,29N,11W	Texas			x	x			B			
W. Tarkio Cr.	P	1.2	Mouth	14,65N,40W	Atchison		x	x	x			B		x	
W. Tarkio Cr.	C	9.6	14,65N,40W	State Line	Atchison		x	x	x			B			
W. Yellow Cr.	C	17.2	14,61N,19W	14,63N,19W	Sullivan			x	x			B		x	
W. Yellow Cr.	P	43.3	Mouth	14,61N,19W	Chariton	Sullivan		x	x			B	x	x	
Wachita Cr.	C	0.5	Mouth	28,34N,5E	Madison			x	x			B			
Wade Cr.	C	5.4	Mouth	9,43N,25W	Henry			x	x			B			
Wakenda Cr.	P	29.2	Mouth	4,52N,25W	Carroll			x	x			B			
Wakenda Cr.	C	10.6	4,52N,25W	33,54N,26W	Carroll			x	x			B			
Walkers Slough	PI	1.6	Mouth	6,57N,4W	Marion			x	x			B			
Walkers Slough	C	3.5	6,57N,4W	24,58N,5W	Marion			x	x			B			
Wallace Cr.	P	3.3	Mouth	05,40N,06W	Gasconade			x	x			B			
Wallace Cr.	C	1.9	05,40N,06W	07,40N,06W	Gasconade			x	x			B			
Wallen Cr.	P	1.4	Mouth	9,36N,3E	Washington			x	x			B			
Wallen Cr.	C	3.0	9,36N,3E	6,36N,3E	Washington			x	x			B	x		
Wallen Cr.	C	1.1	Mouth	27,36N,3E	Washington			x	x			B			
Walnut Br.	C	2.7	Mouth	12,45N,23W	Pettis			x	x			B			
Walnut Cr.	C	10.1	Mouth	28,39N,33W	Bates			x	x			B			
Walnut Cr.	P	2.3	Mouth	17,36N,28W	St. Clair	Cedar		x	x			B			
Walnut Cr.	C	3.6	25,45N,21W	2,44N,21W	Pettis			x	x			B			
Walnut Cr.	C	2.3	Mouth	03,34N,30W	Vernon			x	x			B			
Walnut Cr.	C	15.7	Mouth	2,61N,17W	Macon	Adair		x	x			B			
Walnut Cr.	C	3.5	Mouth	20,55N,14W	Randolph			x	x				x		
Walnut Cr.	C	2.7	Mouth	27,47N,26W	Johnson			x	x			B			
Walnut Cr.	P	1.3	Mouth	25,45N,21W	Pettis			x	x			B			
Walnut Cr.	C	11.9	Mouth	14,46N,24W	Johnson			x	x			B	x		
Walnut Fk.	C	4.3	Mouth	22,62N,32W	Gentry			x	x			B			
Wamsley Cr.	C	1.7	Mouth	27,58N,30W	DeKalb			x	x				x		

IRR LWW AQL CLF CDF WBC SCR DWS IND

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SCR-Secondary Contact Recreation  
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WATER BODY	CLASS	MILES	FROM	TO	COUNTY	COUNTY 2	IRR	LWW	AQL	CLF	CDF	WBC	SCR	DWS	IND
Ward Br.	P	3.3	Mouth	13,28N,22W	Greene			x	x			B			
Wardens Br.	C	1.0	Mouth	18,46N,5W	Montgomery			x	x			B			
Warm Fk. Spring R.	P	13.8	State Line	25,23N,06W	Oregon		x	x	x			A	x		
Warm Fk. Spring R.	C	9.4	25,23N,06W	8,23N,6W	Oregon			x	x			B			
Warren Br.	P	1.5	State Line	36,26N,34W	Newton			x	x			B			
Warren Br.	C	1.5	36,26N,34W	29,26N,33W	Newton			x	x			B			
Wash Cr.	P	1.2	Mouth	27,32N,8E	Madison			x	x			B			
Wash Cr.	C	0.5	27,32N,8E	26,32N,8E	Madison			x	x			B			
[Water Fk.]	P	5.8	Mouth	12,34N,4W	Dent	Bollinger		x	x			B			
Water Fk. Cr.															
Watkins Cr.	C	1.4	Mouth	Hwy. 270	St. Louis City	St. Louis		x	x			B			
Watson Br.	C	1.0	Mouth	20,39N,1E	Washington			x	x			B			
Weanbleau Cr.	P	30.7	Mouth	[03,35N,23W]	St. Clair	Hickory		x	x			A	x		
				3,35N,23W											
Web Cr.	P	4.7	Mouth	5,28N,2E	Reynolds			x	x			B			
Web Valley	P	3.0	Mouth	11,28N,2E	Reynolds			x	x			B			
Weidensaul Hollow	C	3.0	Mouth	26,23N,13W	Ozark			x	x			B			
Weldon Br.	C	4.4	Mouth	8,63N,30W	Gentry			x	x			B			
Weldon R.	P	43.4	Mouth	State Line	Grundy	Mercer		x	x			B			
West Ditch	P	10.5	31,18N,10E	8,19N,10E	Dunklin			x	x			B			
West Elm Br.	P	1.1	Mouth	29,33N,33W	Barton			x	x			B			
West Fk.	P	1.0	Mouth	7,34N,23W	Polk			x	x			B			
West Fk.	C	3.0	Mouth	14,38N,5E	Jefferson	St. Francois		x	x			B			
West Fk.	C	6.8	Mouth	8,31N,31W	Barton			x	x			B			
West Prong Indian Cr.	C	2.0	6,25N,7E	36,26N,6E	Butler			x	x			B			
Wet Fk.	C	1.5	Mouth	5,28N,5E	Wayne			x	x			B			
Wet Fk.	P	2.4	Mouth	29,27N,6E	Wayne			x	x			B			
Wet Glaize Cr.	P	9.6	24,38N,15W	20,37N,14W	Camden			x	x			A	x		
Wheeler Cr.	C	2.4	Mouth	31,58N,30W	DeKalb			x	x			B			
Whetstone Cr.	P	12.2	Mouth	21,29N,13W	Wright			x	x	x		B			
Whetstone Cr.	P	1.5	Mouth	7,48N,6W	Montgomery			x	x			B			
Whetstone Cr.	C	10.8	7,48N,6W	1,48N,8W	Callaway			x	x			B			
Whippoorwill Cr.	C	2.3	Mouth	16,47N,5W	Montgomery			x	x			B			
Whisky Cr.	C	1.5	Mouth	18,43N,1W	Franklin			x	x			B			
Whitcomb Br.	C	2.5	Mouth	36,49N,1W	Lincoln			x	x			B	x		
White Br.	C	3.4	Mouth	32,36N,31W	Vernon			x	x			B			
White Cloud Cr.	P	13.2	Mouth	24,63N,36W	Andrew	Nodaway		x	x			B			
White Cloud Cr.	C	12.8	24,63N,36W	11,64N,36W	Nodaway			x	x			B			
White Cr.	C	3.5	9,24N,2W	4,24N,2W	Oregon			x	x			B			
White Oak Cr.	C	4.0	Mouth	30,42N,12W	Cole			x	x			B			
White Oak Cr.	C	3.9	Mouth	28,42N,28W	Henry			x	x			B			
White Oak Cr.	C	2.6	Mouth	33,50N,5W	Montgomery			x	x			B			
White Oak Cr.	C	18.0	Mouth	2,29N,28W	Jasper	Lawrence	x	x	x			A			
White Oak Cr.	C	9.0	Mouth	[Hwy. 136]	Harrison			x	x			B			
				14,63N,29W											
White Oak Hollow	C	2.0	Mouth	28,32N,5W	Dent			x	x			B			
Whitener Cr.	P	0.5	Mouth	28,32N,8E	Madison			x	x			B			

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WATER BODY	CLASS	MILES	FROM	TO	COUNTY	COUNTY 2	IRR	LWW	AQL	CLF	CDF	WBC	SCR	DWS	IND
Whitener Cr.	C	1.5	[28,32N,8E] 27,32N,8E	22,32N,8E	Madison			x	x			B			
Whites Cr.	P	2.0	Mouth	26,39N,2W	Crawford			x	x			B			
Whites Cr.	C	1.0	26,39N,2W	35,39N,2W	Crawford			x	x			B			
Whites Cr.	C	3.0	Mouth	33,26N,15W	Douglas			x	x			B			
Whites Cr.	P	4.5	Mouth	9,24N,2W	Oregon			x	x			B			
Whitewater R.	P	35.0	Mouth	[29,33N,11E] 29,33N,11E	Cape Girardeau			x	x			A			
Whitewater R.	P	18.0	29,33N,11E	29,34N,9E	Bollinger	Perry		x	x	x		A		x	
Whitewater R.	C	5.9	29,34N,9E	10,34N,8E	Perry	St. Francois		x	x			B			
Whitewater R.	P	5.0	[31,28N,12E] Mouth	6,28N,12E	Scott		x	x	x			B			
Whitewater R.	C	5.2	6,28N,12E	18,29N,12E	Scott	Cape Girardeau		x	x			B			
Whittenburg Cr.	P	2.8	Mouth	35,38N,4W	Crawford			x	x		x	B			
Whittenburg Cr.	C	5.0	[35,38N,4W] 34,38N,4W	[1,37N,4W] 11,37N,4W	Crawford			x	x			B		x	
Widow Cr.	C	1.6	Mouth	36,26N,3E	Butler			x	x			B			
Wiener Cr.	P	2.3	[11,40N,12W] Mouth	23,40N,12W	Miller			x	x			B			
Wiener Cr.	C	4.0	23,40N,12W	2,39N,12W	Miller			x	x			B			
Wiencke Br.	C	1.0	Mouth	9,44N,14W	Moniteau			x	x			B			
Wildcat Cr.	C	4.0	Mouth	3,62N,39W	Holt			x	x			B			
Wildcat Cr.	C	7.4	6,62N,32W	8,63N,33W	Gentry	Nodaway		x	x						
Wildcat Cr.	P	6.2	Mouth	6,62N,32W	Gentry			x	x			B			
Wildhorse Cr.	C	3.9	Mouth	[29,45N,3E] LG 1956,45N,3E	St. Louis			x	x			B			
Wilkerson Cr.	C	7.3	Mouth	07,52N,32W	Clay			x	x			B		x	
Wilkerson Ditch	C	[4.0]2.7	[9,23N,16E] Mouth	28,24N,16E	Mississippi			x	x			B			
Williams Cr.	P	5.2	Mouth	11,42N,21W	Benton			x	x	x		B			
Williams Cr.	P	9.8	Mouth	Sur 202,31N,13E	Cape Girardeau			x	x			B			
Williams Cr.	C	2.0	[Sur 202,31N,13E] LG 202,31N,13E	[Sur 202,31N,13E] LG 800,32N,13E	Cape Girardeau			x	x			B			
Williams Cr.	C	4.7	Mouth	18,27N,5E	Wayne			x	x			[B]		x	
Williams Cr.	P	1.0	Mouth	28,28N,27W	Lawrence			x	x		x	A			
Williams Cr.	P	8.5	28,28N,27W	34,28N,26W	Lawrence			x	x			A			
Williams Cr.	C	1.5	34,28N,26W	35,28N,26W	Lawrence			x	x			B			
Williams Cr.	C	3.4	11,42N,21W	[05,42N,20W] 5,42N,20W	Benton			x	x			B			
Williams Cr.	P	1.0	Mouth	Sur 880,44N,5E	St. Louis			x	x			B			
Williams Cr.	C	9.1	Mouth	[21,53N,30W] 23,53N,30W	Clay			x	x			B		x	
Williams Cr.	P	1.3	Mouth	24,34N,6E	Madison			x	x			B			
Willow Br.	C	3.4	Mouth	28,24N,26W	Barry			x	x			B			
Willow Br.	P	2.2	Mouth	2,25N,33W	Newton			x	x			B			
Willow Br.	C	2.1	Mouth	05,37N,31W	Vernon			x	x			B			
Willow Cr.	C	2.2	Mouth	19,23N,10W	Ozark	Howell		x	x			B			
Willow Cr.	C	6.5	Mouth	7,51N,27W	Ray			x	x			B			

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WATER BODY	CLASS	MILES	FROM	TO	COUNTY	COUNTY 2	IRR	LWW	AQL	CLF	CDF	WBC	SCR	DWS	IND
Willow Cr.	C	1.0	Mouth	35,61N,32W	Gentry			x	x			B			
Willow Cr.	C	1.5	Mouth	35,55N,26W	Caldwell			x	x			B			
Willow Fk.	P	2.8	[4,44N,16W]	36,45N,17W	Moniteau			x	x			A			
Willow Fk.	C	6.8	Mouth	36,45N,17W	Moniteau			x	x			B			
Wilmore Cr.	C	1.3	Mouth	8,30N,6E	Wayne			x	x			A			
Wilson Br.	C	2.4	Mouth	12,35N,30W	Vernon			x	x			B			
Wilson Run	C	2.5	Mouth	17,24N,23W	Stone			x	x			B			
Wilsons Cr.	P	14.0	Mouth	27,29N,22W	Christian	Greene		x	x			B			
Winigan Cr.	C	7.0	Mouth	5,59N,18W	Linn			x	x			B			
Winn Br.	C	[5.0/6.4	Mouth	21,57N,13W	Macon			x	x			B			
Wolf Cr.	C	9.3	Mouth	16,28N,15W	Wright			x	x			B	x		
Wolf Cr.	C	3.0	Mouth	14,45N,1W	Warren			x	x			B	x		
Wolf Cr.	C	4.5	Mouth	18,49N,4W	Montgomery			x	x			B			
Wolf Cr.	C	3.7	Mouth	35,33N,10E	Cape Girardeau	Bollinger		x	x			B	x		
Wolf Cr.	C	2.0	Mouth	35,25N,5E	Butler			x	x			B			
Wolf Cr.	C	8.0	Mouth	28,36N,6E	St. Francois			x	x			B	x		
Wolf Cr.	C	4.2	Mouth	3,27N,10E	Stoddard			x	x			[B]	x		
Wolf Cr.	C	5.2	Mouth	10,27N,08W	Texas	Howell		x	x			B			
Wolf Cr.	C	1.8	Mouth	32,48N,15W	Cooper			x	x			B			
Wolf Cr.	C	3.0	Mouth	22,45N,32W	Cass			x	x			B			
Wolf Hole Lateral	C	9.5	Mouth	29,26N,16E	Mississippi			x	x			[B]	x		
Wolf Island Chute	P	11.8	5,24N,18E	11,23N,17E	Mississippi			x	x			B			
Woods Fk.	C	5.5	Mouth	3,25N,21W	Christian			x	x			B			
Woods Fk. Gasconade R.	P	12.4	Mouth	2,29N,16W	Wright			x	x			B			
Woods Fk. Gasconade R.	C	4.0	2,29N,16W	6,29N,16W	Wright	Webster		x	x			B			
Woolly Cr.	C	1.5	Mouth	7,23N,24W	Stone			x	x			B			
Woolsey Cr.	C	3.6	Mouth	8,36N,17W	Camden	Laclede		x	x			B			
Workman Br.	C	1.0	Mouth	15,28N,22W	Greene			x	x			B			
Workman Cr.	P	2.4	Mouth	24,45N,13W	Cole			x	x			B			
Wyaconda R.	PI	8.4	Mouth	15,61N,6W	Lewis			x	x			B	x	x	
Wyaconda R.	P	42.2	15,61N,6W	26,65N,9W	Lewis	Clark		x	x			B	x		
Wyrick Br.	C	1.3	Mouth	[10,28N,09W]	Texas			x	x			B			
Yadkin Cr.	C	4.0	Mouth	10,28N,9W	Crawford			x	x		x	B			
Yankee Br.	P	1.4	Mouth	10,36N,4W	Crawford			x	x		x	B			
Yankee Br.	C	1.0	10,36N,4W	10,36N,4W	Crawford			x	x			B			
Yantz Br.	C	1.2	Mouth	Sur 3236,32N,9E	Bollinger			x	x			B			
Yenter Br.	C	2.6	Mouth	30,48N,2W	Warren			x	x			B			
Yellow Cr.	C	2.0	Mouth	29,38N,26W	St. Clair			x	x			B			
Yellow Cr.	P	28.0	Mouth	20,56N,19W	Chariton			x	x			B			
Yoga Spring	P	0.8	Mouth	29,30N,07W	Texas			x	x			B			
Youngs Cr.	C	13.4	Mouth	11,52N,10W	Monroe	Audrain		x	x			B			
Youngs Cr.	C	1.9	Mouth	3,46N,9W	Callaway			x	x			[B]	x		
Zadie Cr.	C	5.3	Mouth	State Line	Harrison			x	x			B			
Zounds Cr.	C	3.0	Mouth	35,64N,33W	Gentry			x	x			B			

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**Table K: Site-Specific Criteria**

Parameter:	Dissolved Oxygen	Daily Average Criterion	3.6 mg/L
Waterbody:	East Fork Locust Creek	Daily average dissolved oxygen concentrations shall not fall below 3.6 mg/L between July 1 and September 30 as measured by a minimum of four samples collected within a 24-hour period. All measurements shall be spaced a minimum of 5 hours apart.	
Season:	July – September		
Hydrology:	Baseflow Conditions		
County:	Sullivan	Daily Minimum Criterion	0.9 mg/L
Miles:	29.6	Daily minimum dissolved oxygen concentration shall not fall below 0.9 mg/L between July 1 and September 30 as measured by the average of three samples collected over any consecutive 6-hour period. All measurements shall be spaced a minimum of 1.5 hours apart.	
From:	Mouth		
To:	Section 12, T64N, R20W		

Parameter:	Dissolved Oxygen	Daily Average Criterion	3.6 mg/L
Waterbody:	Little East Fork Locust Creek	Daily average dissolved oxygen concentrations shall not fall below 3.6 mg/L between July 1 and September 30 as measured by a minimum of four samples collected within a 24-hour period. All measurements shall be spaced a minimum of 5 hours apart.	
Season:	July – September		
Hydrology:	Baseflow Conditions		
County:	Sullivan	Daily Minimum Criterion	0.9 mg/L
Miles:	9.0	Daily minimum dissolved oxygen concentration shall not fall below 0.9 mg/L between July 1 and September 30 as measured by the average of three samples collected over any consecutive 6-hour period. All measurements shall be spaced a minimum of 1.5 hours apart.	
From:	Mouth		
To:	Section 12, T64N, R20W		

Parameter:	Dissolved Oxygen	Daily Average Criterion*	4.4 mg/L
Waterbody:	Sni-a-Bar Creek	Daily average dissolved oxygen concentrations shall not fall below 4.4 mg/L between July 1 and September 30 as measured by a minimum of four samples collected within a 24-hour period. All measurements shall be spaced a minimum of 5 hours apart.	
Season:	July – September		
Hydrology:	Baseflow Conditions		
County:	Jackson	Daily Minimum Criterion*	4.0 mg/L
Miles:	5.0	Daily minimum dissolved oxygen concentration shall not fall below 4.0 mg/L between July 1 and September 30.	
From:	Confluence with Horseshoe Creek, Section 21, T49N, R29W		
To:	Entry of tributary carrying discharge from Blue Springs Sni-a-Bar wastewater treatment plant, Section 35, T49N, R30W		
*These criteria shall expire on October 31, 2014. After October 31, 2014, the criteria shall be as stated in Table A.			

Parameter:	Dissolved Oxygen	Daily Average Criterion	4.7 mg/L
Waterbody:	Pike Creek	Daily average dissolved oxygen concentration shall not fall below 4.7 mg/L during summer baseflow conditions as measured by a minimum of four samples collected within a 24-hour period. All measurements shall be spaced a minimum of 5 hours apart.	
Season:	July – September		
Hydrology:	Baseflow Conditions		
County:	Butler	Daily Minimum Criterion	2.6 mg/L
Miles:	0.1	Daily minimum dissolved oxygen concentrations shall not fall below 2.6 mg/L during summer baseflow conditions.	
From:	Confluence with Main Ditch / Sec. 15, T24N, R6E		
To:	Poplar Bluff Wastewater Treatment Plant / Sec. 15, T24N, R6E		

**Table K: Site-Specific Criteria—continued**

<b>Parameter:</b>	<b>Dissolved Oxygen</b>	<b>Daily Average Criterion</b>	<b>4.7 mg/L</b>
<b>Waterbody:</b>	<b>Main Ditch</b>	<b>Daily average dissolved oxygen concentration shall not fall below 4.7 mg/L during summer baseflow conditions as measured by a minimum of four samples collected within a 24-hour period. All measurements shall be spaced a minimum of 5 hours apart.</b>	
<b>Season:</b>	<b>July – September</b>		
<b>Hydrology:</b>	<b>Baseflow Conditions</b>		
<b>County:</b>	<b>Butler</b>	<b>Daily Minimum Criterion</b>	<b>2.6 mg/L</b>
<b>Miles:</b>	<b>14</b>	<b>Daily minimum dissolved oxygen concentrations shall not fall below 2.6 mg/L during summer baseflow conditions.</b>	
<b>From:</b>	<b>Confluence with Pike Creek / Sec. 15, T24N, R6E</b>		
<b>To:</b>	<b>Confluence with Pike Ditch / Sec. 18, T22N, R6E</b>		

*AUTHORITY: section 644.021, RSMo Supp. [2008] 2010, and section 644.026, RSMo 2000. Original rule filed May 13, 1977, effective Dec. 11, 1977. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Oct. 31, 2011.*

*PUBLIC COST: This proposed amendment will cost publicly owned, domestic wastewater-treatment facilities \$35,239,011 in the aggregate for the construction of wastewater treatment system upgrades as required by this rulemaking and \$34,744,698 annually thereafter for operation and maintenance.*

*PRIVATE COST: This proposed amendment will cost privately owned, domestic wastewater-treatment facilities \$29,256,539 in the aggregate for the construction of wastewater-treatment system upgrades and \$19,395,982 annually thereafter for operation and maintenance.*

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Natural Resources, Division of Environmental Quality, Water Protection Program, John Hoke, PO Box 176, Jefferson City, MO 65102. Comments may be sent with name and address through email to [john.hoke@dnr.mo.gov](mailto:john.hoke@dnr.mo.gov). Public comments must be received by January 18, 2012. The Missouri Clean Water Commission will hold a public hearing at 9 A.M., January 4, 2012, at the Lewis and Clark State Office Building, Nightingale Creek Conference Room, 1 East, 1101 Riverside Drive, Jefferson City, Missouri 65101.*

**FISCAL NOTE  
PUBLIC COST**

**I. RULE NUMBER**

<i>Rule Number and Name:</i>	10 CSR 20-7.031 Water Quality Standards
<i>Type of Rulemaking:</i>	Proposed Amendment

This rulemaking includes revisions that ensure that state water quality standards (WQS) are functionally equivalent to federal standards and that improve the clarity, specificity and effectiveness of the rule. In summary, the revisions include the following:

**Clean Water Act Section 101(a) use designations:** The department is providing a recommendation which responds to the U.S. Environmental Protection Agency (EPA) request that Missouri expand its classification system to currently unclassified waters, or otherwise satisfy the rebuttable presumption of “fishable/swimmable” uses as required by Section 101(a) of the federal Clean Water Act. EPA notified the department of this deficiency by letter on September 8, 2000 following a previous triennial review. More recently, on August 4, 2010, the Washington University Interdisciplinary Environmental Clinic, on behalf of the Missouri Coalition for the Environment, filed suit against EPA to compel the agency to take official action on this deficiency in Missouri rule;

**Clean Water Act use designation definitions:** Addition of a new use designation for Exceptional Aquatic Community will allow for better implementation and protection of aquatic communities in rule. No water body segments are being proposed for this new use designation with this rulemaking;

**Addition of variance authorizing provisions:** This provision would provide the basis for recommending variances to WQS when standards are not achievable through traditional regulatory approaches;

**Revision of schedule of compliance language:** This revision removes the current three-year maximum duration for complying with water quality-based effluent limitations. The department is revising the existing language to provide consistency with federal regulations at 40 CFR 122.47;

**New or revised Clean Water Act Section 304(a) numeric water quality criteria:** Additions and revisions to state water quality criteria based on review of federal criteria developed pursuant to Section 304(a) of the federal Clean Water Act. This modification would bring Missouri's WQS up-to-date with the latest version of federal Section 304(a) criteria for most pollutants;

**Revised numeric water quality criteria for phenol:** In response to an October 12, 2010 petition to the Missouri Clean Water Commission by the Associated Industries of Missouri, the department is proposing revised numeric water quality criteria for phenol. This revision will follow the approach and methods used by EPA in developing new Section 304(a) criteria for phenol;

**Revised numeric water quality criteria for sulfate and chloride:** In response to a February 5, 2010 petition to the Missouri Clean Water Commission by the Missouri Agribusiness Association, the department is proposing revised numeric water quality criteria for sulfate and chloride. This revision will follow the approach and methods used by the State of Iowa to revise its water quality criteria for these parameters;

**Revised numeric water quality criteria for dissolved oxygen:** The department is proposing revisions to the dissolved oxygen criteria for the protection of aquatic life currently found in rule. These revisions will follow the approach and methods used by EPA in developing Section 304(a) criteria for dissolved oxygen;

**Addition of Missouri Department of Conservation and Other Lakes:** This revision would add 8 lakes managed by the Missouri Department of Conservation (MDC), and 38 other lakes with existing uses identified by the department, to the classified waters in Table G;

**Changes to the designation of Whole Body Contact Recreation and Secondary Contact Recreation as a result of Use Attainability Analyses:** These changes are results from the last series of Use Attainability Analyses (UAAs) conducted in 2007 and 2008. This action would include adding whole body contact recreation (WBC) use to 23 stream segments where this use is attainable or existing, designating secondary contact recreation (SCR) to 221 stream segments where existing SCR uses were observed, and removing the WBC use on 111 stream segments where this use is unattainable;

**Responding to EPA's October 29, 2009 decision on the Mississippi River:** The department is also responding to EPA's October 29, 2009 decision that new or revised water quality standards are needed to satisfy the requirements of the federal Clean Water Act for a 28.6-mile segment of the Mississippi River around St. Louis that flows from North Riverfront Park to the confluence with the Meramec River. Based on an overall weight of evidence, the department affirms the current designation of Secondary Contact Recreation (SCR) and associated SCR bacteria criterion for this segment;

**Revised delineation and mileages of water body segments:** These improvements use more accurate Geographic Information System (GIS) data to refine delineations of start and end points of water body segments and recalculate stream mileages; and

**Correction of Typographical Errors:** These changes would correct several typographical errors discovered after the effective date of the last revisions to the WQS in 2009.

## II. SUMMARY OF FISCAL IMPACT

This proposed amendment will cost public entities up to \$35,239,011 in the aggregate for the construction of wastewater treatment system upgrades. In addition, public entities will pay up to \$34,744,698 in the aggregate annually for system operation, maintenance and reporting. It is anticipated that the operation, maintenance and reporting costs will recur over the life of the rule



and will vary with inflation. The majority of costs to public entities are from implementation of federal Clean Water Act Section 101(a) presumed "fishable/swimmable" uses for currently unclassified waters; all other revisions are not anticipated to cost public entities.

Table G, H and Use Designation Dataset – Clean Water Act Section 101(a) Use Designations and Changes to the Designation of Whole Body Contact Recreation and Secondary Contact Recreation as a Result of Use Attainability Analyses

<i>Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule.</i>	<i>Classification by types of the business entities which would likely be affected.</i>	<i>Estimate in the aggregate as to the cost of compliance with the rule by the affected entities.</i>
425 facilities may be required to install a disinfection system to comply with the bacteria standard applicable to waters with recreational uses.	Publicly owned facilities operating domestic wastewater treatment facilities (WWTFs) under a state discharge permit. Examples include: municipal and government-owned facilities with wastewater treatment.	Construction Cost = \$35,239,011 Operation and Maintenance (O&M) Cost = \$34,744,698 - see further breakdown of costs in worksheets below -
185 (137 - Chlorination, 48 - Ultraviolet Light)	Public facilities that do not presently disinfect wastewater discharges with design flows of less than or equal to 0.05 million gallons per day (mgd)	Construction Cost = \$4,192,300 O&M Cost = \$3,939,231
228 (174 - Chlorination, 54 - Ultraviolet Light)	Public facilities that do not presently disinfect wastewater discharges with design flows of greater than 0.05 mgd but less than or equal to 1.0 mgd	Construction Cost = \$11,406,405 O&M Cost = \$29,346,332
12 (5 - Chlorination, 7 - Ultraviolet Light)	Public facilities that do not presently disinfect wastewater discharges with design flows of greater than 1.0 mgd but less than or equal to 20.0 mgd	Construction Cost = \$19,640,306 O&M Cost = \$1,459,134
0	Public facilities that do not presently disinfect wastewater discharges with design flows of greater than 20.0 mgd	\$0

Table A1, A2, and A3 - Changes to the Numeric Criteria for Section 304(a), phenol, sulfate, chloride and dissolved oxygen criteria

<i>Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule.</i>	<i>Classification by types of the business entities which would likely be affected.</i>	<i>Estimate in the aggregate as to the cost of compliance with the rule by the affected entities.</i>
0	Because these changes make the state's criteria consistent with the federal criteria, the fiscal impact of these changes are a result of federal regulations, and therefore already exist. No increase in fiscal impact is expected from this proposed state rule.	\$0

**III. WORKSHEET****Disinfection Systems - Cost Estimates**  
**Chlorination****Public Entities < 0.05 mgd**

	<b>Capital Costs</b>	<b>O&amp;M Costs</b>	<b>Testing Costs</b>
Chlorinator	\$ 1,500		
Dechlorinator	\$ 1,500		
Contact Basin	\$ 7,000		
Subtotal	\$ 10,000		
x 137 Entities	\$ 1,370,000		
Chemicals		\$ 20,000	
Misc.		\$ 2,000	
Subtotal		\$ 22,000	
x 137 Entities		\$ 3,014,000	
25% Contingency	\$ 1,712,500	\$ 3,767,500	
Testing - Fecal Coliform			\$ 35,978
Testing - Total Residual Chlorine			\$ 22,718
Subtotal			\$ 58,695
<b>Total Construction Costs</b>	<b>\$ 1,712,500</b>		
<b>Total Annual O&amp;M and Testing Costs</b>		<b>\$</b>	<b>3,826,195</b>

**Public Entities > 0.05 mgd - < 1.0 mgd**

	<b>Capital Costs</b>	<b>O&amp;M Costs</b>	<b>Testing Costs</b>
Chlorinator	\$ 2,500		
Dechlorinator	\$ 2,500		
Contact Basin	\$ 11,100		
Subtotal	\$ 16,100		
x 174 Entities	\$ 2,801,400		
Chemicals		\$ 122,827	
Misc.		\$ 10,000	
Subtotal		\$ 132,827	
x 174 Entities		\$ 23,111,898	
25% Contingency	\$ 3,501,750	\$ 28,889,873	
Testing - Fecal Coliform			\$ 57,092
Testing - Total Residual Chlorine			\$ 36,050
Subtotal			\$ 93,142
<b>Total Construction Costs</b>	<b>\$ 3,501,750</b>		
<b>Total Annual O&amp;M and Testing Costs</b>		<b>\$</b>	<b>28,983,014</b>

## Disinfection Systems - Cost Estimates Chlorination (Continued)

### Public Entities > 1.0 mgd - < 20 mgd

	Capital Costs	O&M Costs	Testing Costs
Chlorinator	\$ 1,234,933		
Dechlorinator	\$ 387,760		
Uniform Fire Code	\$ 158,956		
Subtotal	\$ 1,781,649		
x 5 Entities	\$ 8,908,245		
O&M Cost		\$ 136,020	
x 5 Entities		\$ 680,100	
25% Contingency	\$ 11,135,306	\$ 850,125	
Testing - Fecal Coliform			\$ 13,134
Testing - Total Residual Chlorine			\$ 8,293
Subtotal			\$ 21,427
<b>Total Construction Costs</b>	<b>\$ 11,135,306</b>		
<b>Total Annual O&amp;M and Testing Costs</b>		<b>\$</b>	<b>871,552</b>

## Disinfection Systems - Cost Estimates Ultraviolet (UV) Light

### Public Entities ≤ 0.05 mgd

	Capital Costs	O&M Costs	Testing Costs
UV Lamps	\$ 13,870		
UV Lamp Installation	\$ 13,590		
Facility Building/Structure	\$ 13,870		
Subtotal	\$ 41,330		
x 48 Entities	\$ 1,983,840		
O&M Cost		\$ 1,750	
x 48 Entities		\$ 84,000	
25% Contingency	\$ 2,479,800	\$ 105,000	
Testing - Fecal Coliform			\$ 8,036
<b>Total Construction Costs</b>	<b>\$ 2,479,800</b>		
<b>Total Annual O&amp;M and Testing Costs</b>		<b>\$</b>	<b>113,036</b>

## Disinfection Systems - Cost Estimates

### Ultraviolet (UV) Light (Continued)

#### Public Entities $\geq 0.05$ mgd - $\leq 1.0$ mgd

	Capital Costs	O&M Costs	Testing Costs
UV Lamps	\$ 39,300		
UV Lamp Installation	\$ 38,506		
Facility Building/Structure	\$ 39,300		
Subtotal	\$ 117,106		
x 54 Entities	\$ 6,323,724		
O&M Cost		\$ 4,956	
x 54 Entities		\$ 267,624	
25% Contingency	\$ 7,904,655	\$ 334,530	
Testing - Fecal Coliform			\$ 28,788
<b>Total Construction Costs</b>	<b>\$ 7,904,655</b>		
<b>Total Annual O&amp;M and Testing Costs</b>		<b>\$</b>	<b>363,318</b>

#### Public Entities $\leq 1.0$ mgd - $\leq 20$ mgd

	Capital Costs	O&M Costs	Testing Costs
UV Lamps	\$ 385,297		
UV Lamp Installation	\$ 297,730		
Facility Building/Structure	\$ 288,973		
Subtotal	\$ 972,000		
x 7 Entities	\$ 6,804,000		
O&M Cost		\$ 65,588	
x 7 Entities		\$ 459,116	
25% Contingency	\$ 8,505,000	\$ 573,895	
Testing - Fecal Coliform			\$ 13,687
<b>Total Construction Costs</b>	<b>\$ 8,505,000</b>		
<b>Total Annual O&amp;M and Testing Costs</b>		<b>\$</b>	<b>587,582</b>

## IV. ASSUMPTIONS

The costs assume that all installations are accomplished over a one-year period. Because most facilities will be allowed a schedule up to three years to complete construction of modified treatment systems, the estimated cost will likely be incurred over a three-year period.

### Chlorination Disinfection Systems

Cost Estimates were derived from cost estimate data provided by a National Small Flows Clearinghouse fact sheet entitled, 'Chlorine Disinfection.' Cost estimates from outside manufacturers of chlorinating tablet feeders were also used for the smaller WWTFs. The

numbers in the 'Chlorine Disinfection' document were from 1995. All of the cost estimates given below have been adjusted to reflect the cost of equipment, O&M costs, and installation cost for year 2004 using the Engineering News Record Construction Cost Index (CCI). The average CCI for 1995 was 5471 and the current CCI is 6825.

Analytical testing costs were established by averaging the cost of fecal coliform and total residual chlorine testing from ten (10) laboratories in Missouri and neighboring states that provide services to facilities from Missouri. The monitoring frequency of each facility is currently established in their permits and was gathered from a Department of Natural Resources database. The cost of analytical testing of fecal coliform and total residual chlorine was based on these monitoring frequencies.

**Assumptions:**

- For flows  $\leq 0.05$  mgd, the average daily discharge flow (ADDF) is 36,000 gallons per day (gpd) and peak flow is 144,000 gpd (peak factor of 4).
- For flows  $>0.05$  mgd and  $\leq 1$  mgd, the ADDF is 255,000 gpd and peak flow is 894,000gpd (peak factor of 3.5).
- Chlorine dose based on peak flows.
- 10 mg/L dosing concentration.
- Tablet chlorination/dechlorination.

### UV Disinfection Systems

Cost estimates were derived from cost estimate data provided by an U.S. Environmental Protection Agency document entitled, 'Ultraviolet Disinfection Technology Assessment.' The numbers in this document were from 1990. All of the cost estimates given below have been adjusted to reflect the cost of equipment, O&M costs, and installation cost for year 2004 using the Engineering News Record Construction Cost Index (CCI). The average CCI for 1990 was 4732 and the current CCI is 6825.

**Assumptions:**

- For flows  $\leq 0.05$  mgd, the ADDF is 36,000 gpd and peak flow is 144,000 gpd (peak factor of 4).
- For flows  $>0.05$  mgd and  $\leq 1$  mgd, the ADDF is 255,000 gpd and peak flow is 894,000 gpd (peak factor of 3.5).
- For flows  $> 1.0$  mgd, the ADDF is 3.6 mgd and peak flow is 10.81 mgd (peak factor of 3).
- 58-inch arc UV lamps were used.
- UV lamps need replacement once per year.
- 1 UV kilowatt = 37 lamps/1 mgd.
- Number of lamps are based on peak flows.
- Cost for constructing a building is approximately equals the cost of lamps for facilities using less than 100 lamps.
- Cost for constructing a building is approximately 75% the cost of lamps for facilities using more than 100 lamps.
- Lagoons were not used for UV disinfection cost.
- Includes redundancy and additional spare lamps.

**FISCAL NOTE  
PRIVATE COST****I. RULE NUMBER**

<i>Rule Number and Name:</i>	10 CSR 20-7.031 Water Quality Standards
<i>Type of Rulemaking:</i>	Proposed Amendment

This rulemaking includes revisions that ensure that state water quality standards (WQS) are functionally equivalent to federal standards and that improve the clarity, specificity and effectiveness of the rule. In summary, the revisions include the following:

**Clean Water Act Section 101(a) use designations:** The department is providing a recommendation which responds to the U.S. Environmental Protection Agency (EPA) request that Missouri expand its classification system to currently unclassified waters, or otherwise satisfy the rebuttable presumption of “fishable/swimmable” uses as required by Section 101(a) of the federal Clean Water Act. EPA notified the department of this deficiency by letter on September 8, 2000 following a previous triennial review. More recently, on August 4, 2010, the Washington University Interdisciplinary Environmental Clinic, on behalf of the Missouri Coalition for the Environment, filed suit against EPA to compel the agency to take official action on this deficiency in Missouri rule;

**Clean Water Act use designation definitions:** Addition of a new use designation for Exceptional Aquatic Community will allow for better implementation and protection of aquatic communities in rule. No water body segments are being proposed for this new use designation with this rulemaking;

**Addition of variance authorizing provisions:** This provision would provide the basis for recommending variances to WQS when standards are not achievable through traditional regulatory approaches;

**Revision of schedule of compliance language:** This revision removes the current three-year maximum duration for complying with water quality-based effluent limitations. The department is revising the existing language to provide consistency with federal regulations at 40 CFR 122.47;

**New or revised Clean Water Act Section 304(a) numeric water quality criteria:** Additions and revisions to state water quality criteria based on review of federal criteria developed pursuant to Section 304(a) of the federal Clean Water Act. This modification would bring Missouri's WQS up-to-date with the latest version of federal Section 304(a) criteria for most pollutants;

**Revised numeric water quality criteria for phenol:** In response to an October 12, 2010 petition to the Missouri Clean Water Commission by the Associated Industries of Missouri, the department is proposing revised numeric water quality criteria for phenol. This revision will follow the approach and methods used by EPA in developing new Section 304(a) criteria for phenol;

**Revised numeric water quality criteria for sulfate and chloride:** In response to a February 5, 2010 petition to the Missouri Clean Water Commission by the Missouri Agribusiness Association, the department is proposing revised numeric water quality criteria for sulfate and chloride. This revision will follow the approach and methods used by the State of Iowa to revise its water quality criteria for these parameters;

**Revised numeric water quality criteria for dissolved oxygen:** The department is proposing revisions to the dissolved oxygen criteria for the protection of aquatic life currently found in rule. These revisions will follow the approach and methods used by EPA in developing Section 304(a) criteria for dissolved oxygen;

**Addition of Missouri Department of Conservation and Other Lakes:** This revision would add 8 lakes managed by the Missouri Department of Conservation (MDC), and 38 other lakes with existing uses identified by the department, to the classified waters in Table G;

**Changes to the designation of Whole Body Contact Recreation and Secondary Contact Recreation as a result of Use Attainability Analyses:** These changes are results from the last series of Use Attainability Analyses (UAAs) conducted in 2007 and 2008. This action would include adding whole body contact recreation (WBC) use to 23 stream segments where this use is attainable or existing, designating secondary contact recreation (SCR) to 221 stream segments where existing SCR uses were observed, and removing the WBC use on 111 stream segments where this use is unattainable;

**Responding to EPA's October 29, 2009 decision on the Mississippi River:** The department is also responding to EPA's October 29, 2009 decision that new or revised water quality standards are needed to satisfy the requirements of the federal Clean Water Act for a 28.6-mile segment of the Mississippi River around St. Louis that flows from North Riverfront Park to the confluence with the Meramec River. Based on an overall weight of evidence, the department affirms the current designation of Secondary Contact Recreation (SCR) and associated SCR bacteria criterion for this segment;

**Revised delineation and mileages of water body segments:** These improvements use more accurate Geographic Information System (GIS) data to refine delineations of start and end points of water body segments and recalculate stream mileages; and

**Correction of Typographical Errors:** These changes would correct several typographical errors discovered after the effective date of the last revisions to the WQS in 2009.

## **II. SUMMARY OF FISCAL IMPACT**

This proposed amendment will cost private entities up to \$29,256,539 in the aggregate for the construction of wastewater treatment system upgrades. In addition, private entities will pay up to \$19,395,982 in the aggregate annually for system operation, maintenance and reporting. It is anticipated that the operation, maintenance and reporting costs will recur over the life of the rule

and will vary with inflation. The majority of costs to private entities are from implementation of federal Clean Water Act Section 101(a) presumed "fishable/swimmable" uses for currently unclassified waters; all other revisions are not anticipated to cost private entities.

Table G, H and Use Designation Dataset – Clean Water Act Section 101(a) Use Designations and Changes to the Designation of Whole Body Contact Recreation and Secondary Contact Recreation as a Result of Use Attainability Analyses

<i>Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule.</i>	<i>Classification by types of the business entities which would likely be affected.</i>	<i>Estimate in the aggregate as to the cost of compliance with the rule by the affected entities.</i>
917 facilities may be required to install a disinfection system to comply with the bacteria standard applicable to waters with recreational uses.	Privately owned facilities operating domestic wastewater treatment facilities (WWTFs) under a state discharge permit. Examples include: municipal and government-owned facilities with wastewater treatment.	Construction Cost = \$29,256,539 Operation and Maintenance (O&M) Cost = \$19,395,982 - see further breakdown of costs in worksheets below -
880 (544 - Chlorination, 336 - Ultraviolet Light)	Private facilities that do not presently disinfect wastewater discharges with design flows of less than or equal to 0.05 million gallons per day (mgd)	Construction Cost = \$24,158,600 O&M Cost = \$15,935,092
36 (19 - Chlorination, 17 - Ultraviolet Light)	Private facilities that do not presently disinfect wastewater discharges with design flows of greater than 0.05 mgd but less than or equal to 1.0 mgd	Construction Cost = \$2,870,878 O&M Cost = \$3,290,585
1 (1 - Chlorination)	Private facilities that do not presently disinfect wastewater discharges with design flows of greater than 1.0 mgd but less than or equal to 20.0 mgd	Construction Cost = \$2,227,061 O&M Cost = \$170,305
0	Private facilities that do not presently disinfect wastewater discharges with design flows of greater than 20.0 mgd	\$0

Table A1, A2, and A3 - Changes to the Numeric Criteria for Section 304(a), phenol, sulfate, chloride and dissolved oxygen criteria

<i>Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule.</i>	<i>Classification by types of the business entities which would likely be affected.</i>	<i>Estimate in the aggregate as to the cost of compliance with the rule by the affected entities.</i>
0	Because these changes make the state's criteria consistent with the federal criteria, the fiscal impact of these changes are a result of federal regulations, and therefore already exist. No increase in fiscal impact is expected from this proposed state rule.	\$0



### III. WORKSHEET

#### Disinfection Systems - Cost Estimates Chlorination

##### Private Entities ≤ 0.05 mgd

	Capital Costs	O&M Costs	Testing Costs
Chlorinator	\$ 1,500		
Dechlorinator	\$ 1,500		
Contact Basin	\$ 7,000		
Subtotal	\$ 10,000		
x 544 Entities	\$ 5,440,000		
Chemicals		\$ 20,000	
Misc.		\$ 2,000	
Subtotal		\$ 22,000	
x 544 Entities		\$ 11,968,000	
25% Contingency	\$ 6,800,000	\$ 14,960,000	
Testing - Fecal Coliform			\$ 106,321
Testing - Total Residual Chlorine			\$ 67,135
Subtotal			\$ 173,456
<b>Total Construction Costs</b>	<b>\$ 6,800,000</b>		
<b>Total Annual O&amp;M and Testing Costs</b>		<b>\$</b>	<b>15,133,456</b>

##### Private Entities > 0.05 mgd - ≤ 1.0 mgd

	Capital Costs	O&M Costs	Testing Costs
Chlorinator	\$ 2,500		
Dechlorinator	\$ 2,500		
Contact Basin	\$ 11,100		
Subtotal	\$ 16,100		
x 19 Entities	\$ 305,900		
Chemicals		\$ 122,827	
Misc.		\$ 10,000	
Subtotal		\$ 132,827	
x 19 Entities		\$ 2,523,713	
25% Contingency	\$ 382,375	\$ 3,154,641	
Testing - Fecal Coliform			\$ 2,709
Testing - Total Residual Chlorine			\$ 1,710
Subtotal			\$ 4,419
<b>Total Construction Costs</b>	<b>\$ 382,375</b>		
<b>Total Annual O&amp;M and Testing Costs</b>		<b>\$</b>	<b>3,159,060</b>

## Disinfection Systems - Cost Estimates

### Chlorination (Continued)

#### Private Entities > 1.0 mgd - < 20 mgd

	Capital Costs	O&M Costs	Testing Costs
Chlorinator	\$ 1,234,933		
Dechlorinator	\$ 387,760		
Uniform Fire Code	\$ 158,956		
Subtotal	\$ 1,781,649		
x 1 Entities	\$ 1,781,649		
O&M Cost		\$ 136,020	
x 1 Entities		\$ 136,020	
25% Contingency	\$ 2,227,061	\$ 170,025	
Testing - Fecal Coliform			\$ 172
Testing - Total Residual Chlorine			\$ 108
Subtotal			\$ 280
<b>Total Construction Costs</b>	<b>\$ 2,227,061</b>		
<b>Total Annual O&amp;M and Testing Costs</b>		<b>\$</b>	<b>170,305</b>

## Disinfection Systems - Cost Estimates

### Ultraviolet (UV) Light

#### Private Entities < 0.05 mgd

	Capital Costs	O&M Costs	Testing Costs
UV Lamps	\$ 13,870		
UV Lamp Installation	\$ 13,590		
Facility Building/Structure	\$ 13,870		
Subtotal	\$ 41,330		
x 336 Entities	\$ 13,886,880		
O&M Cost		\$ 1,750	
x 336 Entities		\$ 588,000	
25% Contingency	\$ 17,358,600	\$ 735,000	
Testing - Fecal Coliform			\$ 66,636
<b>Total Construction Costs</b>	<b>\$ 17,358,600</b>		
<b>Total Annual O&amp;M and Testing Costs</b>		<b>\$</b>	<b>801,636</b>

## Disinfection Systems - Cost Estimates Ultraviolet (UV) Light (Continued)

### Private Entities $\geq 0.05$ mgd - $\leq 1.0$ mgd

	Capital Costs	O&M Costs	Testing Costs
UV Lamps	\$ 39,300		
UV Lamp Installation	\$ 38,506		
Facility Building/Structure	\$ 39,300		
Subtotal	\$ 117,106		
x 17 Entities	\$ 1,990,802		
O&M Cost		\$ 4,956	
x 17 Entities		\$ 84,252	
25% Contingency	\$ 2,488,503	\$ 105,315	
Testing - Fecal Coliform			\$ 26,210
<b>Total Construction Costs</b>	<b>\$ 2,488,503</b>		
<b>Total Annual O&amp;M and Testing Costs</b>		<b>\$</b>	<b>131,525</b>

## IV. ASSUMPTIONS

The costs assume that all installations are accomplished over a one-year period. Because most facilities will be allowed a schedule up to three years to complete construction of modified treatment systems, the estimated cost will likely be incurred over a three-year period.

### Chlorination Disinfection Systems

Cost Estimates were derived from cost estimate data provided by a National Small Flows Clearinghouse fact sheet entitled, 'Chlorine Disinfection.' Cost estimates from outside manufacturers of chlorinating tablet feeders were also used for the smaller WWTFs. The numbers in the 'Chlorine Disinfection' document were from 1995. All of the cost estimates given below have been adjusted to reflect the cost of equipment, O&M costs, and installation cost for year 2004 using the Engineering News Record Construction Cost Index (CCI). The average CCI for 1995 was 5471 and the current CCI is 6825.

Analytical testing costs were established by averaging the cost of fecal coliform and total residual chlorine testing from ten (10) laboratories in Missouri and neighboring states that provide services to facilities from Missouri. The monitoring frequency of each facility is currently established in their permits and was gathered from a Department of Natural Resources database. The cost of analytical testing of fecal coliform and total residual chlorine was based on these monitoring frequencies.

#### Assumptions:

- For flows  $\leq 0.05$  mgd, the average daily discharge flow (ADDF) is 36,000 gallons per day (gpd) and peak flow is 144,000 gpd (peak factor of 4).
- For flows  $>0.05$  mgd and  $\leq 1$  mgd, the ADDF is 255,000 gpd and peak flow is 894,000gpd (peak factor of 3.5).

- Chlorine dose based on peak flows.
- 10 mg/L dosing concentration.
- Tablet chlorination/dechlorination.

### UV Disinfection Systems

Cost estimates were derived from cost estimate data provided by an U.S. Environmental Protection Agency document entitled, 'Ultraviolet Disinfection Technology Assessment.' The numbers in this document were from 1990. All of the cost estimates given below have been adjusted to reflect the cost of equipment, O&M costs, and installation cost for year 2004 using the Engineering News Record Construction Cost Index (CCI). The average CCI for 1990 was 4732 and the current CCI is 6825.

#### **Assumptions:**

- For flows  $\leq 0.05$  mgd, the ADF is 36,000 gpd and peak flow is 144,000 gpd (peak factor of 4).
- For flows  $>0.05$  mgd and  $\leq 1$  mgd, the ADF is 255,000 gpd and peak flow is 894,000 gpd (peak factor of 3.5).
- For flows  $> 1.0$  mgd, the ADF is 3.6 mgd and peak flow is 10.81 mgd (peak factor of 3).
- 58-inch arc UV lamps were used.
- UV lamps need replacement once per year.
- 1 UV kilowatt = 37 lamps/1 mgd.
- Number of lamps are based on peak flows.
- Cost for constructing a building is approximately equals the cost of lamps for facilities using less than 100 lamps.
- Cost for constructing a building is approximately 75% the cost of lamps for facilities using more than 100 lamps.
- Lagoons were not used for UV disinfection cost.
- Includes redundancy and additional spare lamps.

**Title 11—DEPARTMENT OF PUBLIC SAFETY  
Division 45—Missouri Gaming Commission  
Chapter 9—Internal Control System**

**PROPOSED RULE**

**11 CSR 45-9.108 Minimum Internal Control Standards (MICS)—Chapter H**

*PURPOSE: This rule establishes the internal controls for Chapter H of the Minimum Internal Control Standards.*

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here. The Minimum Internal Control Standards may also be accessed at <http://www.mgc.dps.mo.gov>.*

(1) The commission shall adopt and publish minimum standards for internal control procedures that in the commission's opinion satisfy 11 CSR 45-9.020, as set forth in *Minimum Internal Control Standards* (MICS) Chapter H—Casino Cashiering, which has been incorporated by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102. Chapter H does not incorporate any subsequent amendments or additions as adopted by the commission on October 26, 2011.

*AUTHORITY: section 313.004, RSMo 2000, and sections 313.800 and 313.805, RSMo Supp. 2010. Original rule filed Oct. 31, 2011.*

*PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. A public hearing is scheduled for January 11, 2012, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

**Title 12—DEPARTMENT OF REVENUE  
Division 10—Director of Revenue  
Chapter 41—General Tax Provisions**

**PROPOSED AMENDMENT**

**12 CSR 10-41.010 Annual Adjusted Rate of Interest.** The director proposes to amend section (1).

*PURPOSE: The director of revenue proposes to amend section (1) to reflect the interest to be charged on unpaid, delinquent taxes during calendar year 2012.*

(1) Pursuant to section 32.065, RSMo, the director of revenue upon official notice of the average predominant prime rate quoted by com-

mercial banks to large businesses, as determined and reported by the Board of Governors of the Federal Reserve System in the Federal Reserve Statistical Release H.15(519) for the month of September of each year has set by administrative order the annual adjusted rate of interest to be paid on unpaid amounts of taxes during the succeeding calendar year as follows:

Calendar Year	Rate of Interest on Unpaid Amounts of Taxes
1995	12%
1996	9%
1997	8%
1998	9%
1999	8%
2000	8%
2001	10%
2002	6%
2003	5%
2004	4%
2005	5%
2006	7%
2007	8%
2008	8%
2009	5%
2010	3%
2011	3%
2012	3%

*AUTHORITY: section 32.065, RSMo 2000. Emergency rule filed Oct. 13, 1982, effective Oct. 23, 1982, expired Feb. 19, 1983. Original rule filed Nov. 5, 1982, effective Feb. 11, 1983. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Oct. 24, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Oct. 24, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate. This proposed amendment will result in no change to the interest rate charged on delinquent taxes from that of 2011.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate. This proposed amendment will result in no change in the interest rate charged on delinquent taxes from that of 2011. The actual number of affected taxpayers is unknown. See detailed fiscal note for further explanation.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Revenue, Legal Services Division, PO Box 475, Jefferson City, MO 65105-0475. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST****I. RULE NUMBER**

<b>Rule Number and Name:</b>	12 CSR 10-41.010 Annual Adjusted Rate of Interest
<b>Type of Rulemaking:</b>	Proposed Amendment

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Counties	Because the 2012 interest rate imposed on delinquent taxes will be at the same rate imposed in 2011, the aggregate impact on public entities will be less than \$500.
Cities	
Special Taxing Districts	

**III. WORKSHEET**

The proposed amendment sets the rate of interest for 2012 at 3%, the same rate as 2011.

The future amount of past due taxes is unknown. Because the 2012 interest rate imposed on delinquent taxes will be the same rate imposed in 2011, there will be no additional fiscal impact for public entities.

	Current Rule – 3%	Proposed Amendment – 3%
Past due tax amount	\$100.00	\$100.00
Interest amount	3.00	3.00
Total Amount Due	\$103.00	\$103.00

**IV. ASSUMPTIONS**

Pursuant to section 32.065, RSMo, the director of revenue is mandated to establish an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year as set by the Board of Governors of the Federal Reserve rounded to the nearest full percentage.

The actual bank prime loan rate noted by the Federal Reserve in 2011 was 3.25%. Rounded to the nearest whole percentage results in a 3% interest rate.

**FISCAL NOTE  
PRIVATE COST**

**I. RULE NUMBER**

<b>Rule Number and Name:</b>	12 CSR 10-41.010 Annual Adjusted Rate of Interest
<b>Type of Rulemaking:</b>	Proposed Amendment

**II. SUMMARY OF FISCAL IMPACT**

<b>Estimate of the number of entities by class which would likely be affected by adoption of the proposed rule</b>	<b>Classification by types of the business entities which would likely be affected:</b>	<b>Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:</b>
Any taxpayer with delinquent tax.	Any taxpayer with delinquent tax.	Because the 2012 interest rate imposed on delinquent taxes will be at the same rate imposed in 2011, the aggregate impact on private entities will be less than \$500.

**III. WORKSHEET**

The proposed amendment sets the rate of interest for 2012 at 3%, the same rate as 2011.

The future amount of past due taxes is unknown. Because the 2012 interest rate imposed on delinquent taxes will be the same rate imposed in 2011, there will be no additional cost to private entities.

	<b>Current Rule – 3%</b>	<b>Proposed Amendment – 3%</b>
Past due tax amount	\$100.00	\$100.00
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Total Amount Due	\$103.00	\$103.00

**IV. ASSUMPTIONS**

Pursuant to section 32.065, RSMo, the director of revenue is mandated to establish an annual adjusted rate of interest based upon the adjusted prime rate charged by banks during September of that year as set by the Board of Governors of the Federal Reserve rounded to the nearest full percentage.

The actual bank prime loan rate noted by the Federal Reserve in 2011 was 3.25%. Rounded to the nearest whole percentage results in a 3% interest rate.

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**THIS ISSUE CONTAINS  
TWO PARTS**

**END OF PART I**



Volume 36, Number 23  
Pages 2691-2892  
December 1, 2011  
Part II

SALUS POPULI SUPREMA LEX ESTO

*"The welfare of the people shall be the supreme law."*



ROBIN CARNAHAN  
SECRETARY OF STATE

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## IN THIS ISSUE:

### PART I

#### EMERGENCY RULES

##### Department of Revenue

Director of Revenue	.2455
Missouri Consolidated Health Care Plan	
Health Care Plan	.2455

#### PROPOSED RULES

##### Department of Natural Resources

Air Conservation Commission	.2520
Clean Water Commission	.2521

##### Department of Public Safety

Missouri Gaming Commission	.2687
----------------------------	-------

##### Department of Revenue

Director of Revenue	.2687
---------------------	-------

### PART II

##### Department of Corrections

State Board of Probation and Parole	.2695
-------------------------------------	-------

##### Elected Officials

Secretary of State	.2698
--------------------	-------

##### Department of Insurance, Financial Institutions and

##### Professional Registration

Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects	.2701
State Board of Registration for the Healing Arts	.2703
Missouri Real Estate Commission	.2709

##### Missouri Consolidated Health Care Plan

Health Care Plan	.2711
------------------	-------

#### ORDERS OF RULEMAKING

##### Department of Agriculture

Weights and Measures	.2838
----------------------	-------

##### Department of Higher Education

Commissioner of Higher Education	.2840
----------------------------------	-------

##### Department of Public Safety

Missouri Gaming Commission	.2841
----------------------------	-------

##### Department of Social Services

MO HealthNet Division	.2841
-----------------------	-------

##### Retirement Systems

The Public School Retirement System of Missouri	.2849
---	-------

##### Department of Health and Senior Services

Missouri Board of Nursing Home Administrators	.2850
---	-------

##### Department of Insurance, Financial Institutions and

##### Professional Registration

Missouri State Board of Accountancy	.2856
Real Estate Appraisers	.2857

#### IN ADDITIONS

##### Department of Transportation

Missouri Highways and Transportation Commission	.2858
---	-------

##### Department of Health and Senior Services

Missouri Health Facilities Review Committee	.2859
---	-------

#### CONTRACTOR DEBARMENT LIST

#### DISSOLUTIONS

#### SOURCE GUIDES

##### RULE CHANGES SINCE UPDATE

##### EMERGENCY RULES IN EFFECT

##### EXECUTIVE ORDERS

##### REGISTER INDEX

Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
August 1, 2011 August 15, 2011	September 1, 2011 September 15, 2011	September 30, 2011 September 30, 2011	October 30, 2011 October 30, 2011
September 1, 2011 September 15, 2011	October 3, 2011 October 17, 2011	October 31, 2011 October 31, 2011	November 30, 2011 November 30, 2011
October 3, 2011 October 17, 2011	November 1, 2011 November 15, 2011	November 30, 2011 November 30, 2011	December 30, 2011 December 30, 2011
November 1, 2011 November 15, 2011	December 1, 2011 December 15, 2011	December 31, 2011 December 31, 2011	January 30, 2012 January 30, 2012
December 1, 2011 December 15, 2011	January 3, 2012 January 17, 2012	January 30, 2012 January 30, 2012	February 29, 2012 February 29, 2012
January 3, 2012 January 17, 2012	February 1, 2012 February 15, 2012	February 29, 2012 February 29, 2012	March 30, 2012 March 30, 2012
February 1, 2012 February 15, 2012	March 1, 2012 March 15, 2012	March 31, 2012 March 31, 2012	April 30, 2012 April 30, 2012

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at <http://www.sos.mo.gov/adrules/pubsched.asp>

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St. Louis University Law Library 3700 Lindell Blvd. St. Louis, MO 63108-3478 (314) 977-2742	Riverside Regional Library PO Box 389, 1997 E. Jackson Blvd. Jackson, MO 63755-0389 (573) 243-8141	Missouri State Library 600 West Main, PO Box 387 Jefferson City, MO 65102-0387 (573) 751-3615	Barry-Lawrence Regional Library 213 6th St. Monett, MO 65708-2147 (417) 235-6646
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## HOW TO CITE RULES AND RSMo

**RULES**—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 28, *Missouri Register*, page 27. The approved short form of citation is 28 MoReg 27.

The rules are codified in the *Code of State Regulations* in this system—

Title	Code of State Regulations	Division	Chapter	Rule
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

**RSMo**—The most recent version of the statute containing the section number and the date.

**Title 14—DEPARTMENT OF CORRECTIONS  
Division 80—State Board of Probation and Parole  
Chapter 3—Conditions of Probation and Parole**

**PROPOSED AMENDMENT**

**14 CSR 80-3.010 Conditions of Probation and Parole.** The division is amending sections (1) through (10) and adding sections (11) through (13).

*PURPOSE: This amendment clarifies the conditions of supervision, provides current contact information for the Missouri Board of Probation and Parole, and incorporates by reference the Rules and Regulations Governing The Conditions Of Probation, Parole, and Conditional Release, revised December 2009.*

*PUBLISHER'S NOTE: The division has determined that the publication of the entire text of material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.*

(1) The first condition reads, “[Laws] **LAWS:** I will obey all the federal and state laws, municipal and county ordinances. I will report all arrests to my probation and parole officer within forty-eight (48) hours.” [All of us are expected to obey the laws. If a parolee, or probationer is arrested at any time for any reason, s/he must report his/her arrest to his/her probation and parole officer within forty-eight (48) hours.]

(2) The second condition reads, “[Travel] **TRAVEL:** I will obtain advance permission from my probation and parole officer before leaving the state or the area in which I am living.” [The probation and parole officer must always know where his/her clients are. It will be the probation and parole officer who will determine the area in which the probationer or parolee will be allowed to travel. There may be times when a probationer or parolee will be living in one (1) community and working in another. When this does occur, the probation and parole officer usually limits the area of travel to these two (2) communities. There may be other exceptions from time-to-time which should be discussed with the officer. When the request is reasonable, the officer will allow the probationer or parolee to travel based on a written travel permit for each occasion or without getting his/her permission each time. This will generally depend on the circumstances. If the probationer or parolee travels outside Missouri, there are certain regulations and requirements that must be followed. A travel permit will have to be issued to the probationer or parolee by the probation and parole officer. Since there is a certain amount of paper work involved in preparing these travel permits, the probationer or parolee should discuss his/her travels with his/her probation and parole officer far enough in advance to allow time for the proper paper work to be prepared. Travel permits for travel outside Missouri may be issued on short notice only in case of emergency, such as serious illness or death in the family.]

(3) The third condition reads, “[Residency: I will notify my probation and parole officer of any changes of residency within forty-eight (48) hours.” Since the probation and parole officer is at all times responsible for knowing his/her clients' place of residence, it is essential for probationers and parolees to notify their officer within forty-eight (48) hours of any change they must make in regard to where they are

living. The officer may need to contact a client for some reason or may be planning to stop by the client's home for a visit. This condition is an effort to keep the probationer or parolee and the probation and parole officer in close touch with each other.] **RESIDENCY:** I will obtain advance permission from my probation and parole officer before making any change in residency.

(4) The fourth condition reads, “[Employment] **EMPLOYMENT:** I will maintain employment unless engaged in a specific program approved by my probation and parole officer. I will obtain advance permission from my probation and parole officer before quitting my job or program. In the event I lose my job or am terminated from a program, I will notify my probation and parole officer within forty-eight (48) hours.” [Changing or quitting a job is always a major decision in anyone's life. It is a decision that a probationer or parolee needs to discuss with his/her probation and parole officer before finally deciding what to do. The probation and parole officer can point out the advantages and disadvantages of making the job change. There are many times when a decision of this kind is made on the spur of the moment and without too much thought. One (1) of the main purposes of this rule, therefore, is to help the probationer or parolee to avoid making a decision which s/he may well regret later on by not being able to find another job quickly. Most of us are expected to support ourselves, have a family to support or debts to pay. It is a normal expectation that these obligations be met. This is no different for a person under supervision than it is for any other citizen. We have found over the years that involvement in criminal behavior and unemployment are closely related. During the supervision period a probationer or parolee will be expected to maintain employment. The only excuse from this obligation will be his/her involvement in a specific program such as vocational training, drug or alcohol abuse treatment or other programs related to his/her self improvement. A probationer or parolee must remember that before quitting or changing a job or program, s/he must have advance permission from his/her probation and parole officer. In the event a probationer or parolee is fired from a job or program, s/he has the obligation to notify his/her probation and parole officer within forty-eight (48) hours.]

(5) The fifth condition reads, “[Association: I will not associate with any person who has been convicted of a felony or misdemeanor.” As a probationer or parolee reviews his/her past life and thinks about how s/he got involved in difficulty with the law, many times the probationer or parolee will have to admit that his/her association with some other person who previously had been in difficulty, played a role in his/her situation. This condition is to help probationers and parolees avoid this mistake in the future. It will be the probationer's or parolee's responsibility to know with whom s/he associates. We would caution probationers and parolees to select their friends and associates wisely. Naturally there will be times when a probationer's or parolee's work and place of residency will place him/her in contact with persons who have been convicted of felonies and misdemeanors. The mere fact that the probationer or parolee lives in the same rooming house or works in the same place of employment does not mean that s/he has to associate after working hours or outside the place of residence. If because of place of residency or employment the probationer or parolee finds him/herself in association with someone who has been convicted, s/he should advise his/her probation and parole officer of the circumstances.] **ASSOCIATION:** I will obtain advance permission from my probation and parole officer before I associate with any person convicted of a felony or misdemeanor,

or with anyone currently under the supervision of the Board of Probation and Parole. It is my responsibility to know with whom I am associating.

(6) The sixth condition reads, “[*Drugs*] **DRUGS:** I will not have in my possession or use any controlled substance except as prescribed for me by a licensed medical practitioner.” [*Use of any controlled substance unless prescribed by a physician is illegal. Therefore, the use or possession of drugs is not only a violation of his/her probation and parole conditions but is also a violation of the law.*]

(7) The seventh condition reads, “[*Weapons: I will, if my probation or parole is based on a misdemeanor involving firearms or explosives, or any felony charge, not own, possess, purchase, receive, sell or transport any firearms, ammunition or explosive device or any dangerous weapon as defined by federal, state or municipal laws or ordinances.*” If a probationer is a misdemeanor offender and the misdemeanor for which s/he is now on probation did not involve firearms or explosives then s/he is excluded from the condition, unless for other reasons his/her probation and parole officer, the parole board or the court, feel that it is pertinent to his/her success under supervision. Then they may invoke this condition as a special condition of his/her probation or parole. This condition does apply to any individual who has been convicted of a misdemeanor that relates to or involves firearms or explosives and to all individuals who are on probation or parole as a result of a felony conviction. The Federal Firearms Act will cause this condition of restrictions on firearms past the end of a probation or parole period. As it stipulates, it is illegal for a person to have a firearm if s/he has been convicted of a misdemeanor involving firearms or explosives or any law of the state punishable by a term of imprisonment of two (2) years or more. At the time of a probationer or parolee’s discharge from probation or parole, s/he should consult with his/her probation and parole officer as to how to obtain relief through the Department of Treasury, Bureau of Alcohol, Tobacco and Firearms Division to the restrictions placed upon the probationer or parolee regarding his/her possession and use of firearms.] **WEAPONS:** I will not own, possess, purchase, receive, sell, or transport any firearms, ammunition, or explosive device, or any dangerous weapon if I am on probation or parole for a felony charge or a misdemeanor involving firearms or explosives, or if it is in violation of federal, state, or municipal laws or ordinances.

(8) The eighth condition reads, “[*Reporting/Directives*] **REPORTING/DIRECTIVES:** I will report as directed to my probation and parole officer. I [*agree to*] will abide by any directives given me by my probation and parole officer.” [*The probation and parole officer may have a probationer or parolee report to him/her in a number of different ways, such as his/her personal appearance at his/her office or some other designated place from time-to-time or to send in a monthly supervision report at a designated time. As part of a probationer’s or parolee’s reporting, s/he may request that s/he bring documents such as check stubs, receipts for restitution or court costs, receipts for installment payments, income tax forms, all of which will be helpful to the officer in planning with the probationer or parolee towards a successful parole and probation period. If the probationer or parolee tries to contact his/her probation and parole office by telephone and s/he is not in at the time of the call, the probationer or parolee must identify him/herself to someone in the office and tell why s/he is calling and why s/he wants to see his/her probation and parole officer. In this way the person at the office can inform the probation and parole officer of the call or the proba-*

*tioner or parolee’s wish to see him/her. The probation and parole officer can then get in touch with the probationer or parolee as soon as s/he is able to do so. The officer from time-to-time may give the probationer or parolee special directives that will relate to him/her as an individual. This may not be a condition of the probation or parole as specified on that document; however, they still may be directives that have an important impact as the probationer or parolee and his/her officer plan together for the probationer’s or parolee’s future. For example, if the probationer or parolee decides to marry, it is advisable for him/her to consult with his/her probation and parole officer and obtain his/her advice and suggestions in this regard. The probation and parole officer may very well wish to interview the probationers or parolees prospective marriage partner in order to make sure that there are no legal barriers to the marriage or misunderstanding between the two (2) of them that might cause difficulty in the marriage at a later date. Obviously, no probationer or parolee is allowed to live in a common law relationship since it is not legal in this state. If a probationer or parolee is living in such a relationship at the time s/he is placed on probation, it will be the responsibility of the probation and parole officer to work with him/her and his/her common law spouse towards consummating the relationship by marriage. Another directive could regard installment buying of some type. Buying a particular item on installments is very easy to do but installment payments are not always easy to make. To help a probationer or parolee avoid getting into financial difficulty, s/he should discuss installment purchasing with his/her probation and parole officer.]*

(9) The ninth condition reads, “[*Special Conditions.*” Both the Division of Probation and Parole and the court that has placed a person on probation have the authority to determine special conditions of probation or parole supervision. Depending on the circumstances of the situation, special conditions may include things such as prohibiting a probationer or parolee from consuming alcoholic beverages, requiring him/her to stay in a halfway house for a certain period or requiring him/her to be involved in an educational-vocational training program. Special conditions may also set out certain restrictions that are placed upon a probationer or parolee if s/he is released for medical or mental treatment. Special conditions are frequently used for setting court costs, fines and restitution. On occasion they will be used to require that the probationer or parolee not visit a specific location or area. These are but examples of special conditions that may be imposed and they certainly are not limited to the previously mentioned list. They are as important as any of the preceding eight (8) conditions of probation and parole and failure to abide by any special condition as stated on an order will be considered a violation of probation or parole.] **SUPERVISION STRATEGY:** I will enter and successfully complete any supervision strategy and abide by all rules and program requirements, as directed by the court, board, or my supervising probation and parole officer.

(10) [*Location of the central office of the Board of Probation and Parole (where the board members can be found), field probation and parole offices and institutional parole offices are as follows:*

(A) Central office is at 211 Marshall, Jefferson City;

(B) Field offices are in St. Joseph, Chillicothe, Hannibal, Kansas City (two (2) locations), Warrensburg, Columbia, St. Louis City (four (4) locations), St. Louis County (two (2) locations), Carthage, Springfield, Rolla, Farmington, West Plains, Sikeston, Hillsboro, Union, St. Charles, Macon, North Kansas City, Camdenton, Branson, Cape Girardeau, Kennett,

*Independence, Poplar Bluff, Fulton, Jefferson City and Grandview; and*

*(C) Institutional parole offices are at the state penitentiary in Jefferson City, the Algoa correctional center near Jefferson City, the central Missouri correctional center near Jefferson City, the training center at Moberly, the correctional center at Pacific and the Boonville correctional center.] The tenth condition reads, “INTERVENTION FEE: I shall pay a monthly intervention fee in an amount set by Missouri Department of Corrections pursuant to section 217.690, RSMo. This payment shall be due and payable on the first day of the first month following placement on probation, or acceptance of an interstate case in the state of Missouri or on the first day of the fourth month following parole, or conditional release.”*

**(11) The eleventh condition reads, “SPECIAL CONDITIONS: Both the Board of Probation and Parole and the court that has placed you on probation, parole, or conditional release have the authority to determine special conditions of your supervision period.”**

**(12) The central office of the Missouri Board of Probation and Parole (where the board members can be found) is located at 3400 Knipp Drive, Jefferson City, Missouri, 65109.**

**(13) The Rules and Regulations Governing the Conditions of Probation, Parole, and Conditional Release, revised December 2009, is hereby incorporated by reference in this rule as published by the Board of Probation and Parole and is available at 3400 Knipp Drive, Jefferson City, Missouri, 65109. This rule does not incorporate any subsequent amendments or additions.**

*AUTHORITY: sections 217.690 and 217.755, RSMo [1986 and 217.690, 2006.] Supp. 2010. This rule was previously filed as 13 CSR 80-3.010. Original rule filed Feb. 5, 1968, effective Feb. 15, 1968. For intervening history, please consult the Code of State Regulations. Amended: Filed Oct. 19, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board of Probation and Parole, Kim Jones-Drury, 3400 Knipp Drive, Jefferson City, MO 65109 or by email at kim.jones-drury@doc.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 14—DEPARTMENT OF CORRECTIONS  
Division 80—State Board of Probation and Parole  
Chapter 3—Conditions of Probation and Parole**

**PROPOSED RULE**

**14 CSR 80-3.020 Conditions of Lifetime Supervision**

*PURPOSE: This rule sets forth conditions of supervision for those placed on lifetime supervision after their terms for a probation, parole, conditional release, or prison sentence have been completed.*

(1) The first condition reads, “LAWS: I will obey all the federal and state laws, municipal and county ordinances. I will report all arrests to my lifetime supervision officer as soon as possible.”

(2) The second condition reads, “GLOBAL POSITIONING SATELLITE MONITORING (GPS): I will abide by the requirements of GPS supervision including maintaining a residence that allows for this supervision to occur.”

(3) The third condition reads, “INTERVENTION FEE: I shall pay a monthly intervention fee in an amount set by Missouri Department of Corrections pursuant to section 217.690, RSMo. This payment shall be due and payable on the first day of the first month following placement on lifetime supervision.”

*AUTHORITY: sections 217.735, 217.755, and 559.106, RSMo Supp. 2010. Original rule filed Oct. 19, 2011.*

*PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Board of Probation and Parole, Kim Jones-Drury, 3400 Knipp Drive, Jefferson City, MO 65109 or by email at kim.jones-drury@doc.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 14—DEPARTMENT OF CORRECTIONS  
Division 80—State Board of Probation and Parole  
Chapter 5—Intervention Fee**

**PROPOSED AMENDMENT**

**14 CSR 80-5.010 Definitions for Intervention Fee.** The division is amending subsection (1)(C).

*PURPOSE: This amendment modifies definition of waiver used in this chapter.*

(1) For the purpose of 14 CSR 80-5[:]/—

(C) The term “waiver” means an offender is temporarily relieved of an obligation to pay all or part of the intervention fee, based on the offender’s confinement, program involvement, or income, as authorized by the supervising officer and the [district administrator] Chief Administrative Officer (CAO)/designee;

*AUTHORITY: sections 217.040, 217.690, and 217.755, RSMo [2000 and section 217.690, RSMo Supp. 2007] Supp. 2010. Emergency rule filed Oct. 6, 2005, effective Nov. 1, 2005, expired April 29, 2006. Original rule filed Oct. 6, 2005, effective April 30, 2006. Amended: Filed Aug. 1, 2008, effective Jan. 30, 2009. Amended: Filed Oct. 19, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in*

support of or in opposition to this proposed amendment with the Missouri Board of Probation and Parole, Kim Jones-Drury, 3400 Knipp Drive, Jefferson City, MO 65109 or by email at kim.jones-drury@doc.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 14—DEPARTMENT OF CORRECTIONS  
Division 80—State Board of Probation and Parole  
Chapter 5—Intervention Fee**

**PROPOSED AMENDMENT**

**14 CSR 80-5.020 Intervention Fee Procedure.** The division is amending paragraphs (1)(I)1. and 2.

*PURPOSE:* This amendment redefines the designated collection agency in the process for sanctions regarding nonpayment.

(1) The following procedures apply to the collection of an offender intervention fee.

(I) The following process for sanctions regarding nonpayment shall be applied:

1. The designated [collection] agency is responsible for collecting payments of the intervention fee;

2. Upon receiving notification from the designated [collection] agency that an offender has failed to submit the intervention fee, the supervising officer will remind the offender of the payment obligation during their next contact;

3. The supervising officer should direct the offender to specific programs or services that will assist him/her in addressing their inability to pay (i.e., financial management program, employment counseling and/or job seeking classes, substance abuse counseling, mental health counseling, etc.);

4. When willful nonpayment occurs over a period of ninety (90) consecutive days, the supervising officer shall submit a notice of citation or violation report;

5. Offenders who are not current on their intervention fee payments may not be eligible for transfer to minimum supervision, interstate transfer, or early discharge consideration;

6. Sanctions for willful nonpayment of intervention fees include, but are not limited to the following:

A. Written reprimand from district administrator or parole board;

B. Travel restriction;

C. Community service;

D. Increased level of supervision; and

E. Shock detention;

7. Unpaid intervention fees owed by offenders committed to the Division of Adult Institutions (DAI) will be collected from the inmate's account; and

8. All intervention fees collected by the department will be deposited in the inmate fund established in section 217.430, RSMo, with expenditures occurring as authorized through the state budget appropriation process.

*AUTHORITY:* sections 217.040, 217.690, and 217.755, RSMo [2000 and section 217.690, RSMo Supp. 2007] Supp. 2010. Emergency rule filed Oct. 6, 2005, effective Nov. 1, 2005, expired April 29, 2006. Original rule filed Oct. 6, 2005, effective April 30, 2006. Amended: Filed Aug. 7, 2006, effective Feb. 28, 2007. Amended: Filed Aug. 1, 2008, effective Jan. 30, 2009. Amended: Filed Oct. 19, 2011.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board of Probation and Parole, Kim Jones-Drury, 3400 Knipp Drive, Jefferson City, MO 65109 or by email at kim.jones-drury@doc.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 15—ELECTED OFFICIALS  
Division 30—Secretary of State  
Chapter 200—State Library**

**PROPOSED AMENDMENT**

**15 CSR 30-200.010 State and Federal Grants—Definitions.** The State Library is amending subsection (2)(C), adding a new subsection (2)(G), and relettering subsequent subsections accordingly.

*PURPOSE:* This amendment removes the definition of library advisory committee, adds new definitions for library consortium and the secretary's council on library development and renumbers remaining subsections.

(1) As used in 15 CSR 30-200.010 to 15 CSR 30-200.030, the following terms shall mean:

(C) [Library advisory committee is a committee established by the secretary of state made up of representatives from all areas of the state which may include legislators, public library trustees, citizens, and librarians from all types of libraries. This committee advises the state librarian and the secretary of state on statewide library concerns, federal grant programs, state aid to public libraries, and all matters that relate to Missouri libraries and library service to Missouri citizens; recommends policy and programs; and communicates the value of libraries to people in the state and to those responsible for libraries] Library consortium is any local, statewide, regional, interstate, or international cooperative association of library entities which provides for the systematic and effective coordination of the resources of school, public, academic, and special libraries and information centers and for improved services for the clientele of such library entities;

(G) Secretary's Council on Library Development is a committee established by the secretary of state made up of representatives from all areas of the state which may include legislators, public library trustees, citizens, and librarians from all types of libraries. This committee advises the state librarian and the secretary of state on statewide library concerns, federal grant programs, state aid to public libraries, and all matters that relate to Missouri libraries and library service to Missouri citizens; recommends policy and programs; and communicates the value of libraries to people in the state and to those responsible for libraries;

[(G)](H) Special library is a library established by an organization and designed to serve the special needs of its employees or clientele; and

[(H)](I) State aid to public libraries is a sum appropriated by the legislature for distribution among the public libraries of the state as specified in section 181.060, RSMo [(1994)] 2000.

*AUTHORITY:* section[s] 181.021, RSMo Supp. [1996] 2010 and section 181.060, RSMo [1994] 2000. Emergency rule filed Nov. 18, 1996, effective Nov. 28, 1996, expired May 26, 1997. Original rule filed Nov. 18, 1996, effective May 30, 1997. Amended: Filed Oct. 31, 2011.



**PUBLIC COST:** *This proposed amendment will not cost state agencies or political subdivision more than five hundred dollars (\$500) in the aggregate.*

**PRIVATE COST:** *This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

**NOTICE TO SUBMIT COMMENTS:** *Anyone may file a statement in support of or opposition to this proposed amendment by email to [brenda.alleebates@sos.mo.gov](mailto:brenda.alleebates@sos.mo.gov), by fax to (573) 751-3612, or in writing to Brenda Allee-Bates, Missouri State Library, PO Box 387, Jefferson City, MO 65102-0387. To be considered, comments must be in writing and must be received within thirty (30) days after publication in the Missouri Register. No public hearing is scheduled.*

**Title 15—ELECTED OFFICIALS  
Division 30—Secretary of State  
Chapter 200—State Library**

**PROPOSED AMENDMENT**

**15 CSR 30-200.020 State and Other Grants-in-Aid.** The State Library is amending the rule title, purpose, subsections (2)(A), (2)(B), (3)(A), (3)(B), (3)(F), (4)(A), (4)(B), (4)(C), (4)(E), (6)(B), (7)(A), (7)(B), and paragraphs (4)(D)3., and (4)(E)1.; is deleting paragraphs (4)(E)2., and (4)(E)3., and section (5); and renumbering sections (6) and (7).

**PURPOSE:** *This amendment adds language relating to tax funds for libraries, changes the date for filing certification documentation with the state library, clarifies the process for state aid to newly established libraries, specifies how eligibility may be determined for libraries receiving directed distribution of funds, how applications for aid will be reviewed, clarifies the grant period and payment schedule, how interest must be applied for grant funds, competitive bid requirements, requests for extension of grant period, budget changes, and project modifications.*

**PURPOSE:** *This rule establishes eligibility requirements and procedures for the administration of state and other types of grants-in-aid appropriated to the state library for the improvement of library services, including state aid for public libraries. These funds are administered by the state librarian under the direction of the secretary of state.*

(2) Each of the following requirements must be met for participation in state grants-in-aid:

(A) A public library must be legally established according to the provisions of Chapter 182, RSMo [(1994), as amended], or other laws of the state related to libraries;

(B) A public library must receive from tax funds an amount equal to ten cents per one hundred dollars (10¢:\$100) assessed valuation authorized in accordance with the applicable provisions within Chapter 182[,] or section 137.030, RSMo [1994, as amended]. A city library which is not supported by a library tax must receive an appropriation from the city of an amount equal to ten cents per one hundred dollars (10¢:\$100) assessed valuation. The requisite funds must be assessed and levied, or **in the case of a city library not supported by a library tax, otherwise [appropriated in the case of a city library not supported by a library tax,] expended**, for the fiscal year preceding that in which the grant is made. No grant shall be affected because of a reduction in the rate of levy which is required by the provisions of section 137.073, RSMo [1994, as amended] or because of a voluntary reduction in the levy following the enactment of a district sales tax under section 182.802, RSMo, if the proceeds from the sales tax equal or exceed the reduction in revenue from the levy;

(3) Per Capita Grants of State Aid for Public Libraries.

(A) During each fiscal year, the state librarian will distribute to eligible public libraries on a per capita basis at least fifty percent (50%) of all moneys appropriated by the general assembly as state aid to public libraries, the allocation of which shall be made in accordance with section 181.060.2, RSMo [1994, as amended].

(B) All eligible public libraries shall file the certification required by section 181.060.3, RSMo [1994, as amended], with the state library no later than [June 30] **July 31** of each year. The state library will provide certification forms with instructions to all public libraries annually and upon request.

(F) Per capita state aid grants will be remitted to all certified libraries [in quarterly payments].

(4) Other Grants of State Aid To Public Libraries Under Section 181.060, RSMo.

(A) For each fiscal year, the state librarian, in [his/her] **his or her** discretion, shall administer and supervise grants to public libraries of the balance of all moneys appropriated by the general assembly pursuant to, in accordance with, and for the purposes set forth in section 181.060.4, RSMo [1994, as amended].

(B) State aid grants to newly established library districts [will] **may** be made in accordance with the certification process in section 181.060.4, RSMo [1994, as amended].

(C) For appropriations which designate a directed distribution of funds to libraries which meet specific eligibility criteria, the state library will solicit information from the libraries to determine which ones are eligible for participation. **Alternatively, eligibility may be determined by using published data from various sources including state and federal agencies.**

(D) For appropriations for which the funds are awarded on a competitive basis, the following application process will be used:

1. Applications must be submitted in the form and manner prescribed by the state library[,] and must include all required signatures;

2. Applications shall include the following information, at a minimum. Additional information and supporting documentation may be requested as appropriate to the type of applications:

A. Description of the project that includes the benefit to be provided to users of the library, project goals, action plan, and a schedule of implementation;

B. Staffing level and expertise sufficient to accomplish the project;

C. Project budget, including specification of any required local matching funds;

D. Indication that the project can be completed within the specified grant period; and

E. Plan for the evaluation of the project;

3. All applications will be examined by state library staff for completeness, compliance with regulations and eligibility criteria, and adherence to instructions. **Applications may also be examined by a review committee composed of representatives from libraries and other appropriate institutions or agencies.** Requests to the applying library for additional information or verification of information must be responded to within the time frames specified by state library staff. Completeness, compliance with regulations and eligibility criteria do not obligate the state librarian or the secretary of state to award any grant. However, applications that are incomplete, substantively inaccurate, or received after the deadline shall be rejected; and

4. The state librarian shall review the applications[,] and provide the secretary of state with recommendations for grant awards. The secretary of state shall make the final ruling on funding of specific applications. Applications may be granted in whole or in part.

(E) Grant Period and Payment Schedule.

1. The grant period [begins and ends on the dates specified in the grant letter. Grants must be completed within the fiscal year (July 1 to June 30) in which the grant is awarded] and

payment schedule are specified in the award packet. Grant moneys may take longer to issue than the official grant *[notification letter] packet*. While the grantee cannot charge expenses incurred before the grant period begins, appropriate charges incurred after the grant period begins but before the moneys are available, are allowed.

*[2. Grantees receiving twenty thousand dollars (\$20,000) or less shall receive seventy percent (70%) of the grant funds as soon after the awarding of the grant as practicable. The remaining thirty percent (30%) of the grant shall be paid to the grantee after successful project completion and submission of all required reports.*

*3. Grantees receiving more than twenty thousand dollars (\$20,000) shall receive a first payment of thirty-five percent (35%) as soon as practicable after the awarding of the grant. A second payment of thirty-five percent (35%) shall be made after one-third (1/3) of the project completion is verified through an interim report; with the remaining thirty percent (30%) paid upon successful project completion and submission of all required reports.*

#### *(5) Appeal Procedures.*

*(A) Any library denied funding may inform the state library in writing of its intent to seek a hearing. This letter of intent must be received by the state library within fifteen (15) days following notice of the funding decisions.*

*(B) The state library shall convene a meeting of an independent committee to consider the library's appeal. The state library, the appellant, and the president of the Missouri Library Association or his/her designee shall each choose one (1) person to serve on the committee.*

*(C) Unless extended by written agreement of the state library and the appellant, the appeals committee shall meet no later than fifteen (15) days following the receipt of the appeal by the state librarian. The appellant library and the state library may, but need not, be represented by counsel and may, through staff, appear before the committee to testify.*

*(D) The committee shall make written recommendation to the secretary of state regarding the appeal. The decision of the secretary of state is final.]*

#### *[(6)](5) Audit Requirements.*

*(A) Grantees must comply with the audit requirements set forth in Missouri statutes for local governmental units. The grantee is responsible for ensuring that the state library receives copies of the audit report in a timely fashion.*

*(B) Specific accounting requirements for competitive grants awarded under the state aid to public libraries and state grants-in-aid programs are—*

*1. Grant money must be deposited in an auditable [interest-bearing] account [and interest must be applied to the project]. When grant funds are deposited in an interest-bearing account, all interest over one hundred dollars (\$100) must be applied to the project;*

*2. Grant work will be monitored in progress. State library staff may visit the project site(s) for review at any time during the grant cycle;*

*3. The grantee must submit [an interim] report(s) on the grant project, [in] by the date and using the form(s) provided by the state library. The report shall [include a narrative of] indicate the work completed, and include a financial status report;*

*4. Any items or services purchased by the grantee [in excess of three thousand dollars (\$3,000) must be competitively bid and require the solicitation of at least three (3) bids. If three (3) bids are not received, proof of bid solicitation is sufficient] must conform to the competitive bid requirements of section 34.040, RSMo. Proof of bid solicitation on all such items must be submitted with the financial reports;*

*5. Projects using in-kind contributions as local matches will need to [submit] include appropriate proof (for example, records of hours worked), with the financial reports;*

*6. [Any changes in the project, including changes in budget allocations and project director, must be requested in advance in writing to the state library] Requests for extension of the grant period, budget changes, or other modifications to the project shall be made in writing to the state library no later than three (3) weeks prior to the end of the grant period. The state librarian may, at his or her discretion, allow an amendment subject to the appropriation and availability of funds;*

*7. In the event of default on the grant project by the grantee, the grant will be revoked and all funds must be returned to the state library. The grantee will be notified by letter by the state library and will receive thirty (30) days['] written notice of noncompliance before the grant is revoked; and*

*8. The grantee shall prepare a final report on the grant project. Forms will be provided for both segments of the final report, 1) project summary and evaluation and 2) final financial report.*

*[(7)](6) Federal and Other Types of Grants to Libraries. Unless otherwise expressly provided for, any appropriations made by the general assembly other than appropriations made under section 181.060, RSMo, with respect to which the state library is designated as the administering agent shall be distributed pursuant to applications or requests for proposals governed to the greatest degree practicable by the procedures set forth in sections (4) through (6) hereinabove with the following exceptions:*

*[(A) Applications for appropriations of funds awarded on a competitive basis will be reviewed by an independent committee appointed by the state librarian. Committee members may include, but are not limited to, members of the library advisory committee and representatives of the library community. The independent committee shall receive copies of all eligible applications and selection criteria prior to the review meeting. The independent committee shall evaluate each application and make its recommendations on funding. The state librarian shall review the committee recommendations, and provide the secretary of state with recommendations for grant awards. The secretary of state shall make the final ruling on the applications to be funded; and*

*(B) The state librarian may, in his/her discretion, allow extensions for grant project completion, subject to the appropriation and availability of funds. Requests for extension of the grant period must be made in writing to the state librarian at least one (1) month prior to the end of the grant period.]*

*(A) Funds received from federal sources will follow the federal statutes and regulations of the program involved in addition to applicable state and local statutes and regulations; and*

*(B) Funds received from other private or public sources will follow program guidelines and regulations from the funding source in addition to applicable state and local statutes and regulations.*

*AUTHORITY: section[s] 181.021, RSMo Supp. [1996] 2010, [and] sections 181.060 and 182.812(3), RSMo [1994] 2000, and section 182.802, HB 161, First Regular Session, Ninety-sixth General Assembly, 2011. Emergency rule filed Nov. 18, 1996, effective Nov. 28, 1996, expired May 26, 1997. Original rule filed Nov. 18, 1996, effective May 30, 1997. Amended: Filed Oct. 31, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or opposition to this proposed amendment by email to [brenda.alleebates@sos.mo.gov](mailto:brenda.alleebates@sos.mo.gov), by fax to (573) 751-3612, or in writing to Brenda Allee-Bates, Missouri State Library, PO Box 387, Jefferson City, MO 65102-0387. To be considered, comments must be in writing and must be received within thirty (30) days after publication in the **Missouri Register**. No public hearing is scheduled.*

**Title 20—DEPARTMENT OF INSURANCE,  
FINANCIAL INSTITUTIONS AND PROFESSIONAL  
REGISTRATION**

**Division 2030—Missouri Board for Architects,  
Professional Engineers, Professional Land Surveyors,  
and Landscape Architects  
Chapter 2—Code of Professional Conduct**

**PROPOSED AMENDMENT**

**20 CSR 2030-2.040 Standard of Care.** The board is proposing to amend the purpose statement and section (1).

*PURPOSE: This rule is being amended to reflect the current edition of the International Building Code, Section 107.*

*PURPOSE: This rule provides the recipient and producer of professional architectural, engineering, and/or landscape architectural services assurances that all services are evaluated in accordance with the 2009 edition of the **International Building Code**, Section [106] 107.*

(1) The board shall use, in the absence of any local building code, Section [106] 107 only of the 2009 edition of the *International Building Code*, not including or applying any other sections referenced within Section [106] 107, as the standard of care in determining the appropriate conduct for any professional licensed or regulated by this chapter and being evaluated under section 327.441.2(5), RSMo. The *International Code Council*, 2009 Edition is incorporated herein by reference and may be obtained by contacting 500 New Jersey Ave NW, 6th Floor, Washington, DC 20001, by phone at 1 (888) ICC-SAFE (422-7233), by fax at (202) 783-2348, or by their direct website at <http://www.iccsafe.org>. This rule does not incorporate any subsequent amendments or additions to the manual.

*AUTHORITY: section 327.041, RSMo Supp. [2008] 2010. Original rule filed June 14, 2007, effective Dec. 30, 2007. Amended: Filed July 22, 2009, effective Jan. 30, 2010. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board of Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via email at [moapels@pr.mo.gov](mailto:moapels@pr.mo.gov). To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**Title 20—DEPARTMENT OF INSURANCE,  
FINANCIAL INSTITUTIONS AND PROFESSIONAL  
REGISTRATION**

**Division 2030—Missouri Board for Architects,  
Professional Engineers, Professional Land Surveyors,  
and Landscape Architects  
Chapter 2—Code of Professional Conduct**

**PROPOSED AMENDMENT**

**20 CSR 2030-2.050 Title Block.** The board is proposing to amend section (1).

*PURPOSE: This rule is being amended to include land surveying entities.*

(1) An architectural, engineering, **land surveying**, or landscape architectural entity shall incorporate a title block on all drawings and other documents required to be signed and sealed by Chapter 327, RSMo, and these regulations.

*AUTHORITY: sections 327.041 and 327.411, RSMo Supp. [2006] 2010. Original rule filed June 14, 2007, effective Dec. 30, 2007. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board of Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via email at [moapels@pr.mo.gov](mailto:moapels@pr.mo.gov). To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**Title 20—DEPARTMENT OF INSURANCE,  
FINANCIAL INSTITUTIONS AND PROFESSIONAL  
REGISTRATION**

**Division 2030—Missouri Board for Architects,  
Professional Engineers, Professional Land Surveyors,  
and Landscape Architects  
Chapter 11—Renewals**

**PROPOSED AMENDMENT**

**20 CSR 2030-11.015 Continuing Professional Competency for Professional Engineers.** The board is proposing to amend section (6).

*PURPOSE: This rule is being amended to allow ten (10) professional development hours (PDHs) for obtaining a patent.*

(6) Credits. PDHs of credit for qualifying courses successfully completed that offer semester hour, quarter hour, or CEU credit is as specified in this rule. All other activities permit the earning of one (1) PDH of credit for each contact hour with the following exceptions:

(C) Five (5) PDHs are earned for a paper or article that is published in a nationally circulated technical journal or article. Credit cannot be claimed until that article or paper is actually published; [and]

**(D) A one-time award of ten (10) PDHs will be granted for obtaining a work-related patent; and**

**[(D)](E)** Notwithstanding the provisions above, PDHs will only be awarded for the first occurrence of attending or teaching a qualifying course or seminar per every two (2)-year renewal period.

*AUTHORITY: section 327.041, RSMo Supp. [2007] 2010, and section 327.261, RSMo 2000. This rule originally filed as 4 CSR 30-11.015. Original rule filed Nov. 1, 2001, effective June 30, 2002. For intervening history, please consult the Code of State Regulations. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board of Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via email at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

## **Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION**

### **Division 2030—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects Chapter 11—Renewals**

#### **PROPOSED AMENDMENT**

**20 CSR 2030-11.035 Continuing Education for Landscape Architects.** The board is proposing to add paragraph (4)(A)11.

*PURPOSE: This rule is being amended to allow ten (10) continuing education units for obtaining a patent.*

(4) Activities.

(A) The following suggested list may be used by all licensed landscape architects in determining the types of activities that may fulfill continuing education requirements:

1. Contact hours in attendance at short courses or seminars, dealing with landscape architectural, architectural, engineering, or land surveying subjects, as appropriate to each discipline and sponsored by colleges or universities;

2. Contact hours in attendance at technical presentations on subjects which are held in conjunction with conventions or at seminars related to materials use and function. Such presentations as those sponsored by the Council of Landscape Architectural Registration Boards (CLARB), American Society of Landscape Architects (ASLA), or similar organizations devoted to landscape architectural, architectural, engineering, or land surveying education may qualify;

3. Contact hours in attendance at short courses or seminars, relating to business practice or new technology and offered by colleges, universities, professional organizations, or system suppliers;

4. Contact hours spent in self-study courses sponsored by the CLARB, ASLA, or similar organizations;

5. Three (3) units preparing for each class hour spent teaching landscape architectural courses or seminars. Credit is allowed for first occurrence of teaching course or seminar per two (2)-year

renewal period. College or university faculty may not claim credit for teaching regular curriculum courses;

6. Contact hours spent in landscape architectural research, which is published or formally presented to the profession or public;

7. College or university credit courses dealing with landscape architectural subjects or business practice. Each semester hour shall equal fifteen (15) CEUs;

8. Contact hours spent in professional service to the public that draws upon the licensee's professional expertise on boards or commissions, such as: serving on planning commissions, park boards, city council, county commissions, or state registration boards;

9. Contact hours, maximum of one (1) per annum, spent actively participating in a technical profession society or organization as an officer or member of a committee; *[or]*

10. Contact hours spent in education tours of landscape architecturally significant projects, where the tour is sponsored by a college, university, or professional organization~~[/]; or~~

**11. A one-time award of ten (10) CEUs will be granted for obtaining a work-related patent.**

*AUTHORITY: sections 327.041 and 327.621, RSMo Supp. [2008] 2010, and sections 41.946 and 327.171, RSMo 2000. Original rule filed Jan. 15, 2008, effective July 30, 2008. Amended: Filed April 3, 2009, effective Sept. 30, 2009. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Board of Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via email at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

## **Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION**

### **Division 2030—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects Chapter 14—Definitions**

#### **PROPOSED RESCISSION**

**20 CSR 2030-14.050 Definition of Degree in Science as Used in Section 327.391, RSMo.** This rule provided a clear definition of the words degree in science as those words are used in section 327.391, RSMo.

*PURPOSE: During the 2006 legislative session, the Missouri General Assembly passed HB 1494 and SB 819, which removed degree in science as a qualification for licensure as an engineer or professional land surveyor. This rule is being rescinded since it is no longer applicable.*

*AUTHORITY: section 327.041, RSMo 1986. This rule originally filed as 4 CSR 30-14.050. Original rule filed Jan. 12, 1984, effective April 12, 1984. Moved to 20 CSR 2030-14.050, effective Aug. 28, 2006. Rescinded: Filed Nov. 1, 2011.*

**PUBLIC COST:** This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

**PRIVATE COST:** This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Board of Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, PO Box 184, Jefferson City, MO 65102 or via email at [moapels@pr.mo.gov](mailto:moapels@pr.mo.gov). To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,  
FINANCIAL INSTITUTIONS AND PROFESSIONAL  
REGISTRATION**

**Division 2150—State Board of Registration for the  
Healing Arts**

**Chapter 2—Licensing of Physicians and Surgeons**

**PROPOSED AMENDMENT**

**20 CSR 2150-2.150 Minimum Requirements for Reinstatement of Licensure.** The board is proposing to amend section (1).

**PURPOSE:** This amendment would revise the basic minimum requirements that a physician must meet in order to reinstate his/her license after it has been revoked, suspended, or inactive. This amendment removes a reference to two (2) exams that are outdated and adds another option for evaluation at a specialized assessment center in order to ensure that a physician is competent to practice medicine in Missouri.

(1) The board may require each applicant seeking to restore to good standing a license, certificate, or permit issued under Chapter 334, RSMo, which has been revoked, suspended, or inactive for any reason for more than two (2) years, to present with his/her application evidence to establish the following:

(A) Satisfactorily completing twenty-five (25) hours of continuing medical education courses[, *either*] American Medical Association Category 1, [*or*] American Osteopathic Association Category 1A or 2A, **or American Academy of Family Practice Prescribed credit**, for each year during which the license, certificate, or permit was revoked, suspended, or inactive; and

(B) Successfully-passing, during the revoked, suspended, or inactive period, one (1) of the following:

1. [*the*] **The American Specialty Board's** certifying examination in the physician's field of specialization[.];

2. [*Component 2 of the Federation Licensing Examination (FLEX) before January 1, 1994, Step 3 of the United States Medical Licensing Examination (USMLE) or the*] **The Federation of State Medical Board's Special Purpose Examination (SPEX);**

3. **An assessment by the Center for Personalized Physician Education Program (CPEP), 7351 Lowry Boulevard, Suite 100, Denver, CO 80230, the University of California, San Diego, Physician Assessment and Clinical Education Program (PACE), 1899 McKee Street, Suite 126, San Diego, CA 92110, or other agency jointly agreed to by the licensee and the board.**

**AUTHORITY:** section[s] 334.100.5, *RSMo Supp. 2010*, and section 334.125, *RSMo 2000*. This rule originally filed as 4 CSR 150-2.150. Original rule filed Jan. 19, 1988, effective April 15, 1988. For inter-

vening history, please consult the *Code of State Regulations*. Amended: Filed Nov. 1, 2011.

**PUBLIC COST:** This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

**PRIVATE COST:** This proposed amendment will cost private entities approximately fourteen thousand four hundred fifty dollars (\$14,450) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Registration for the Healing Arts, Tina Steinman, Executive Director, PO Box 4, Jefferson City, MO 65102, by faxing comments to (573) 751-3166, or by emailing comments to [healingarts@pr.mo.gov](mailto:healingarts@pr.mo.gov). To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**PRIVATE FISCAL NOTE****I. RULE NUMBER****Title 20 - Department of Insurance, Financial Institutions and Professional Registration****Division 2150 - State Board of Registration for the Healing Arts****Chapter 2 - Licensing of Physicians and Surgeons****Proposed Rule - 20 CSR 2150-2.150 Minimum Requirements for Reinstatement of Licensure**

Prepared August 5, 2011 by the Division of Professional Registration

**II. SUMMARY OF FISCAL IMPACT**

<b>Estimate the number of entities by class which would likely be affected by the adoption of the proposed</b>	<b>Classification by type of the business entities which would likely be affected:</b>	<b>Estimated cost of compliance with the amendment by affected entities:</b>
1	CPEP Assessment @ \$7,550.00	\$7,550.00
1	PACE Assessment @ \$6,900.00	\$6,900.00
<b>Estimated Annual Cost of Compliance for the Life of the Rule</b>		<b>\$14,450.00</b>

**III. WORKSHEET**

See Table Above

**IV. ASSUMPTION**

1. The figures reported above are based on FY11 actuals.
2. Skill assessment examination fees are set by the agency and are the responsibility of the applicant.
3. It is anticipated that the total cost will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

**Title 20—DEPARTMENT OF INSURANCE,  
FINANCIAL INSTITUTIONS AND PROFESSIONAL  
REGISTRATION**

**Division 2150—State Board of Registration for the  
Healing Arts**

**Chapter 3—Licensing of Physical Therapists and  
Physical Therapist Assistants**

**PROPOSED AMENDMENT**

**20 CSR 2150-3.010 Applicants for Licensure as Professional  
Physical Therapists.** The board is proposing to amend section (2).

*PURPOSE:* This amendment sets forth the requirements for internationally trained applicants as passed in Senate Bill 788 (2008).

(2) The applicant must furnish satisfactory evidence of completion of a program of physical therapy education approved as reputable by the board. If the applicant graduated on or before December 31, 2002, he/she must present evidence that his/her physical therapy degree is the equivalent of a bachelor's degree in physical therapy from a United States college or university. If the applicant graduated after December 31, 2002, he/she must present evidence that his/her physical therapy degree is equivalent in content to the first professional degree in physical therapy in the United States as defined by the Federation of State Boards of Physical Therapy (FSBPT) [as defined in the Coursework Evaluation Tool for the Evaluation of Foreign Educated Physical Therapist, dated May 2004, which is incorporated herein by reference as published by the FSBPT, or its successor agency, available upon request from this office or upon request from the FSBPT], 124 West Street South, Third Floor, Alexandria, VA 22314, (703) 299-3100. [This rule does not incorporate any subsequent amendments or additions.] An internationally trained applicant who graduated on or before December 31, 2002, must have education and training in physical therapy substantially equivalent to a bachelor's degree in physical therapy from a United States college or university. An internationally trained applicant who graduated after December 31, 2002, must have education and training in physical therapy substantially equivalent to the first professional degree in physical therapy in the United States as defined by FSBPT. This includes an assessment of the applicant's general and professional education. Applicants who wish to have their general and professional education considered "substantially equivalent" must submit their credentials to the Foreign Credentialing Commission of Physical Therapy (FCCPT), 124 West Street South, Third Floor, Alexandria, VA 22314 (703) 684-8406. The FCCPT shall use the coursework evaluation tool for foreign educated physical therapists as developed by the FSBPT and evaluate the applicant's credentials against the requirements at accredited physical therapy programs in place at the time of the applicant's graduation. An applicant who presents satisfactory evidence of graduation from a physical therapy program approved as reputable by the Commission on Accreditation in Physical Therapy Education, or its successor, shall be deemed to have complied with the education requirements of this section.

*AUTHORITY:* section 334.125, RSMo 2000, and sections 334.530, 334.540, 334.550, and 334.687, RSMo Supp. [2008] 2010. This rule originally filed as 4 CSR 150-3.010. Original rule filed Dec. 19, 1975, effective Dec. 29, 1975. For intervening history, please consult the Code of State Regulations. Amended: Filed Nov. 1, 2011.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will cost private entities

approximately three thousand two hundred forty-five dollars (\$3,245) biennially for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Registration for the Healing Arts, Tina Steinman, Executive Director, PO Box 4, Jefferson City, MO 65102, by faxing comments to (573) 751-3166, or by emailing comments to [healingarts@pr.mo.gov](mailto:healingarts@pr.mo.gov). To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**PRIVATE ENTITY FISCAL NOTE****I. RULE NUMBER****Title 20 - Department of Insurance, Financial Institutions and Professional Registration****Division 2150 - State Board of Registration for the Healing Arts****Chapter 3 - Licensing of Physical Therapists and Physical Therapist Assistants****Proposed Amendment - 20 CSR 2150-3.010 Applicants for Licensure as Professional Physical Therapists**

Prepared October 31, 2011 by the Division of Professional Registration

**II. SUMMARY OF FISCAL IMPACT****First Year of Implementation of Rule**

Estimate the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimated cost of compliance with the rule by affected entities:
11	International Applicants (Educational Evaluation by FCCPT @ \$295)	\$3,245
	<b>Estimated Biennial Cost of Compliance for the Life of the Rule</b>	<b>\$3,245</b>

**III. WORKSHEET**

See table above.

**IV. ASSUMPTION**

1. The above figures are based on FY11 actuals.
2. International applicants submit the evaluation fee directly to the Foreign Credentialing Commission of Physical Therapy (FCCPT).
3. It is anticipated that the total cost will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.



**Title 20—DEPARTMENT OF INSURANCE,  
FINANCIAL INSTITUTIONS AND PROFESSIONAL  
REGISTRATION**

**Division 2150—State Board of Registration for the  
Healing Arts**

**Chapter 6—Licensure of Athletic Trainers**

**PROPOSED AMENDMENT**

**20 CSR 2150-6.010 Definitions.** The board is proposing to amend subsections (1)(D), (1)(E), and (1)(F).

*PURPOSE:* This amendment corrects the organization that publishes the *Athletic Training Clinical Proficiencies* which is listed incorrectly in the existing rule and updates the address of the National Athletic Trainers' Association (NATA).

(1) As used in this rule, unless the context clearly requires otherwise, the following terms mean:

(D) Direct supervision—as defined by the National Athletic Trainers' Association Board of Certification, Inc. [(NATA BOC)] or its successor agency between the athletic trainer licensed pursuant to Chapter 334, RSMo, and the [perspective] prospective applicant;

(E) Certified athletic trainer—an athletic trainer certified by the [NATA BOC] National Athletic Trainers' Association Board of Certification, Inc. or its successor agency;

(F) Educational quality equal—as defined in *Athletic Training Clinical Proficiencies*, 4th Edition, November 6, 2009, which is incorporated herein by reference as published by the [NATA BOC] National Athletic Trainers' Association, Inc. or its successor agency, available upon request from this office or upon request from the [NATA BOC, 4223 South 143rd Circle, Omaha, NE 68137-4505] National Athletic Trainers' Association Board of Certification, Inc. 2952 Stemmons Freeway #200, Dallas, TX 75247 or its successor agency. This rule does not incorporate any subsequent amendments or additions;

*AUTHORITY:* sections 334.125, RSMo 2000, and 334.706.3(2), RSMo Supp. [2004] 2010. This rule originally filed as 4 CSR 150-6.010. Emergency rule filed April 5, 1985, effective April 15, 1985, expired Aug. 13, 1985. Original rule filed May 3, 1985, effective Aug. 15, 1985. For intervening history, please consult the *Code of State Regulations*. Amended: Filed Nov. 1, 2011.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Registration for the Healing Arts, Tina Steinman, Executive Director, PO Box 4, Jefferson City, MO 65102, by faxing comments to (573) 751-3166, or by emailing comments to [healingarts@pr.mo.gov](mailto:healingarts@pr.mo.gov). To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,  
FINANCIAL INSTITUTIONS AND PROFESSIONAL  
REGISTRATION**

**Division 2150—State Board of Registration for the  
Healing Arts**

**Chapter 6—Licensure of Athletic Trainers**

**PROPOSED AMENDMENT**

**20 CSR 2150-6.020 Applicants for Licensure as Athletic Trainers.** The board is proposing to amend section (4).

*PURPOSE:* This amendment requires the applicant to provide proof of successful passage of the National Athletic Trainers' Association Board of Certification examination pursuant to section 334.708, RSMo.

(4) [If the applicant is applying for licensure as an athletic trainer based upon meeting the National Athletic Trainers Association Board of Certification's (NATA BOC's) or its successor agency's certification qualifications, then the applicant shall provide proof that the NATA BOC or its successor agency's certification is current at the time the application is submitted to the board.] The applicant shall show evidence of having passed the National Athletic Trainers' Association Board of Certification, or its successor agency, examination by having the agency forward a transcript of the applicant's scores directly to the board.

*AUTHORITY:* section[s] 334.125, RSMo 2000, and 334.702, 334.704, 334.706, 334.708, 334.710, and 334.712, RSMo Supp. [2006] 2010. This rule originally filed as 4 CSR 150-6.020. Emergency rule filed April 5, 1985, effective April 15, 1985, expired Aug. 13, 1985. Original rule filed May 3, 1985, effective Aug. 15, 1985. For intervening history, please consult the *Code of State Regulations*. Amended: Filed Nov. 1, 2011.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will cost the National Athletic Trainers' Association Board of Certification, or its successor agency, approximately thirty-five dollars and sixty-four cents (\$35.64) annually for the life of the rule and will cost applicants for licensure approximately two thousand twenty-five dollars (\$2,025) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Registration for the Healing Arts, Tina Steinman, Executive Director, PO Box 4, Jefferson City, MO 65102, by faxing comments to (573) 751-3166, or by emailing comments to [healingarts@pr.mo.gov](mailto:healingarts@pr.mo.gov). To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**PRIVATE FISCAL NOTE****I. RULE NUMBER****Title 20 - Department of Insurance, Financial Institutions and Professional Registration****Division 2150 - State Board of Registration for the Healing Arts****Chapter 6 - Licensure of Athletic Trainers****Proposed Rule - 20 CSR 2150-6.020 Applicants for Licensure as Athletic Trainers**

Prepared October 31, 2011 by the Division of Professional Registration

**II. SUMMARY OF FISCAL IMPACT**

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated annual increase in revenue associated with the amendment by affected entities:
81	Applicants for Licensure (Transcript @ \$25.00)	\$2,025.00
	<b>Estimated Annual Cost of Compliance for the Life of the Rule</b>	<b>\$2,025.00</b>

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated cost of compliance with the amendment by affected entities:
81	NATABOC or successor agency postage (postage @ \$.44)	\$35.64
	<b>Estimated Annual Cost of Compliance for the Life of the Rule</b>	<b>\$35.64</b>

**III. WORKSHEET**

See Table Above

**IV. ASSUMPTION**

1. The figures reported above are based on FY11 actuals.
2. The cost to produce the NATABOC transcript is paid by the applicant. The NATABOC covers the cost of the postage to mail the certification to the board office.
3. It is anticipated that the total cost will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight

**Title 20—DEPARTMENT OF INSURANCE,  
FINANCIAL INSTITUTIONS AND PROFESSIONAL  
REGISTRATION**

**Division 2150—State Board of Registration for the  
Healing Arts**

**Chapter 6—Licensure of Athletic Trainers**

**PROPOSED AMENDMENT**

**20 CSR 2150-6.040 Code of Ethics.** The board is proposing to amend section (1).

*PURPOSE: This amendment refers to the most current version of the National Athletic Trainers' Association Code of Ethics.*

(1) The board and the Missouri Athletic Trainer Advisory Committee adopt and incorporate by reference the *[National Athletic Trainers' Association, Inc. (NATA)] Code of Ethics, [4th Edition] updated September 28, 2005, published by the National Athletic Trainers' Association, Inc. (NATA), 2952 Stemmons Freeway, Dallas, TX 75247*. A copy of the NATA's *Code of Ethics*, 2952 Stemmons Freeway, Dallas, TX 75247, phone: 214-637-6382 is retained at the office of the board and is available to any interested person, upon written request, at a cost not to exceed the actual cost of the reproduction. This rule does not incorporate any subsequent amendments or additions.

*AUTHORITY: section[s] 334.125, RSMo 2000, and section 334.706.3(2), RSMo Supp. [2004] 2010. This rule originally filed as 4 CSR 150-6.040. Emergency rule filed April 5, 1985, effective April 15, 1985, expired Aug. 13, 1985. Original rule filed May 3, 1985, effective Aug. 15, 1985. For intervening history, please consult the Code of State Regulations. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Registration for the Healing Arts, Tina Steinman, Executive Director, PO Box 4, Jefferson City, MO 65102, by faxing comments to (573) 751-3166, or by emailing comments to healingarts@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 20—DEPARTMENT OF INSURANCE,  
FINANCIAL INSTITUTIONS AND PROFESSIONAL  
REGISTRATION**

**Division 2150—State Board of Registration for the  
Healing Arts**

**Chapter 6—Licensure of Athletic Trainers**

**PROPOSED AMENDMENT**

**20 CSR 2150-6.062 Late Registration and Reinstatement.** The board is proposing to delete section (6) and renumber the remaining sections accordingly.

*PURPOSE: This amendment removes the requirement that applicants be actively certified with the National Athletic Trainers' Association pursuant to section 334.708, RSMo.*

*[(6)] All applicants shall be actively certified with the National Athletic Trainers' Association.]*

*[(7)](6) Applicants whose license has been revoked, suspended, or inactive for more than two (2) years shall submit any other documentation requested by the board necessary to verify that the licensee is competent to practice and is knowledgeable of current athletic training techniques, procedures, and treatments, as evidenced by continuing education hours, re-examination, or other applicable documentation acceptable and approved by the board pursuant to the provisions of section 334.100.6, RSMo.*

*[(8)](7) The board may require an applicant to make a personal appearance before the board and/or committee prior to rendering a final decision regarding license renewal/reinstatement.*

*[(9)](8) An applicant may withdraw their application for license any time prior to the board's vote on the applicant's candidacy for license renewal/reinstatement.*

*AUTHORITY: section 334.125, RSMo 2000, and section 334.706.3(2), RSMo Supp. [2007] 2010. Original rule filed Dec. 5, 2007, effective June 30, 2008. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Registration for the Healing Arts, Tina Steinman, Executive Director, PO Box 4, Jefferson City, MO 65102, by faxing comments to (573) 751-3166, or by emailing comments to healingarts@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 20—DEPARTMENT OF INSURANCE,  
FINANCIAL INSTITUTIONS AND PROFESSIONAL  
REGISTRATION**

**Division 2250—Missouri Real Estate Commission  
Chapter 4—Licenses**

**PROPOSED AMENDMENT**

**20 CSR 2250-4.070 Partnership, Association, or Corporation License.** The board is proposing to amend subsection (3)(B).

*PURPOSE: This amendment eliminates the requirement to disclose the names and addresses of all unlicensed partners, officers, and associates.*

(3) At the time of issuance of a partnership, association, or corporation license, the applicant shall make application to the commission on a form approved by the commission which shall include the following:

(B) The name, residence, and business addresses of each Missouri-licensed partner in a partnership, *[or each]* associate in an association, or *[each]* officer of a corporation, *[licensed or unlicensed]*;

*AUTHORITY: sections 339.010, 339.030, 339.040, 339.080, 339.110, 339.120, and 339.160, RSMo Supp. [2008] 2010. This rule originally filed as 4 CSR 250-4.070. Original rule filed Nov. 14,*

1978, effective Feb. 11, 1979. For intervening history, please consult the *Code of State Regulations*. Amended: Filed Oct. 27, 2011.

**PUBLIC COST:** This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

**PRIVATE COST:** This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with the Real Estate Commission, PO Box 1339, Jefferson City, MO 65102, by facsimile at (573) 751-2777, or via email at [realestate@pr.mo.gov](mailto:realestate@pr.mo.gov). To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,  
FINANCIAL INSTITUTIONS AND PROFESSIONAL  
REGISTRATION  
Division 2250—Missouri Real Estate Commission  
Chapter 7—Schools**

**PROPOSED AMENDMENT**

**20 CSR 2250-7.070 General Requirements.** The board is proposing to amend section (2), delete section (11), and renumber the remaining sections accordingly.

**PURPOSE:** This amendment establishes the same requirements for classroom and distance delivery instruction.

(2) For the purpose of the course offerings by accredited real estate schools, an hour means sixty (60) minutes, at least fifty (50) minutes of which shall be devoted to actual [classroom] instruction and no more than ten (10) minutes of which shall be devoted to a recess. Times allotted for supervised examinations may be regarded as hours of instruction.

[[11]] No approved school may offer more than six (6) hours of continuing education classroom instruction to a student in any one (1) day.]

[[12]](11) No part of any approved education course shall be used to solicit membership in organizations, recruit licensees for affiliation with any organization, or advertise the merits of any organization.

[[13]](12) Dates, times, and location(s) of classroom course offerings must be electronically submitted to the commission at least ten (10) days prior to each course offering. Should changes occur in this information, the school must submit the changes immediately via the reporting method prescribed by the commission.

[[14]](13) Advertising for an approved distance delivered course shall clearly describe all course requirements that must be met by the licensee/student, including satisfactory completion of a final examination.

[[15]](14) The student must be physically present in the classroom during one hundred percent (100%) of the actual classroom instruction unless there is good cause as determined by the school and then the school, at its discretion, may allow a student to be absent up to ten percent (10%) of the required hours and still be issued a certificate of attendance. Documentation of duration of absence must be maintained in the school's records.

[[16]](15) No school shall allow anyone to use the school's premises

or classroom to recruit new affiliates for any company one (1) hour before, one (1) hour after, during break periods, lunch periods, or during an instruction period, nor shall any school provide lists of students attending classes to any broker for the purposes of recruiting.

[[17]](16) The school, at the close of any classroom course, shall hand to each individual who has satisfactorily completed the course, a certificate of course completion in a form prescribed by the commission. For licensees who register for the continuing education course on-site without pre-registration, the certificate of course completion must be sent to the licensee within five (5) days of the course completion and the school must have an adequate sign-in/sign-out procedure to ensure attendance and certificate issuance.

[[18]](17) Within no more than ten (10) days of the completion of a course, the school shall electronically submit to the commission in a format prescribed by the commission, a complete and accurate list of attendees who have satisfactorily completed the course.

[[19]](18) All courses of study must be taught in adherence to the outline on file with the commission. In the event a substantive change is proposed, the school must file a revised course outline on a form prescribed by the commission at least thirty (30) days in advance of the scheduled course offering. Approval in writing from the commission must be received prior to implementation of any substantive course change. The commission must respond to any proposed changes within twenty (20) days of receipt.

**AUTHORITY:** sections 339.045, RSMo 2000, and 339.090 and 339.120, RSMo Supp. [2005] 2010. This rule originally filed as 4 CSR 250-7.070. Original rule filed April 6, 2006, effective Sept. 30, 2006. Moved to 20 CSR 2250-7.070, effective Aug. 28, 2006. Amended: Filed Oct. 27, 2011.

**PUBLIC COST:** This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

**PRIVATE COST:** This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with the Real Estate Commission, PO Box 1339, Jefferson City, MO 65102, by facsimile at (573) 751-2777, or via email at [realestate@pr.mo.gov](mailto:realestate@pr.mo.gov). To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,  
FINANCIAL INSTITUTIONS AND PROFESSIONAL  
REGISTRATION  
Division 2250—Missouri Real Estate Commission  
Chapter 8—Business Conduct and Practice**

**PROPOSED AMENDMENT**

**20 CSR 2250-8.030 Branch Offices.** The board is proposing to amend section (3).

**PURPOSE:** This amendment clarifies the allowance for a broker-type licensee to manage more than one (1) office location.

(3) A branch office shall be under the direct supervision of either a licensed broker, broker-salesperson or a broker-partner, broker-associate or broker-officer of the principal licensed broker [who shall

*devote full time to management of the branch office*]; provided that nothing contained in this rule shall be construed to relieve the principal licensed broker from responsibility for all brokerage activities conducted at the branch office. Nothing in this section shall be construed as to prohibit the office manager from engaging in the listing and sale of real estate.

**AUTHORITY:** section 339.120, RSMo Supp. [2008] 2010. This rule originally filed as 4 CSR 250-8.030. Original rule filed Nov. 14, 1978, effective Feb. 11, 1979. For intervening history, please consult the *Code of State Regulations*. Amended: Filed Oct. 27, 2011.

**PUBLIC COST:** This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

**PRIVATE COST:** This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Real Estate Commission, PO Box 1339, Jefferson City, MO 65102, by facsimile at (573) 751-2628, or via email at [realestate@pr.mo.gov](mailto:realestate@pr.mo.gov). To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

## **Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION**

### **Division 2250—Missouri Real Estate Commission Chapter 8—Business Conduct and Practice**

#### **PROPOSED AMENDMENT**

**20 CSR 2250-8.120 Deposits to Escrow or Trust Account.** The commission is proposing to amend the purpose statement.

**PURPOSE:** This rule was previously amended to allow earnest money to be deposited in a noninterest bearing escrow account within ten (10) banking days instead of five (5) banking days. The purpose statement needs to be updated to reflect the same requirements of the rule.

**PURPOSE:** This rule requires all earnest money be deposited in a noninterest bearing escrow account not later than [five] **ten (10)** banking days next following the execution of a contract. If the account is interest-bearing, all parties must be made aware. A salesperson must immediately deliver to the broker all money received in connection with a transaction in which s/he is engaged.

**AUTHORITY:** sections 339.100, 339.105, 339.120, RSMo Supp. [1993] 2010. This rule originally filed as 4 CSR 250-8.120. Original rule filed Nov. 14, 1978, effective Feb. 11, 1979. For intervening history, please consult the *Code of State Regulations*. Amended: Filed Oct. 27, 2011.

**PUBLIC COST:** This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

**PRIVATE COST:** This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with the Real Estate Commission, PO Box 1339, Jefferson City, MO 65102, by facsimile at (573) 751-2777, or via email at [realestate@pr.mo.gov](mailto:realestate@pr.mo.gov). To

be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

## **Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 1—General Organization**

#### **PROPOSED AMENDMENT**

**22 CSR 10-1.010 General Organization.** The Missouri Consolidated Health Care Plan is amending sections (1)–(5).

**PURPOSE:** This amendment changes the policy of the board of trustees in regard to the general organization of the Missouri Consolidated Health Care Plan.

(1) The Missouri Consolidated Health Care Plan [becomes] **became** effective January 1, 1994, under an Act of the general assembly. The plan offers health care coverage for state employees, retirees, and their dependents. It also provides this benefit as an option to all other public entities within the state, as long as they meet admission criteria that may be established by the board of trustees.

(2) The responsibility for the proper operation of the [system] **plan** and the direction of its policies is vested in a board of trustees. The administration of the detailed affairs of the [system] **plan** is in the charge of an executive director, aided by [an assistant executive director] **a chief operations officer**.

(3) The [assistant executive director] **chief operations officer** shall perform duties as may be delegated to him/her by the executive director and in the absence or disability of the executive director shall perform the duties of the executive director.

(4) [House Bill 1574 of the general assembly of Missouri authorized the establishment of the plan.] The statutory provisions relating to the establishment and operation of the plan of [medical] **health** care benefits is provided for in Chapter 103, RSMo. The rules in 22 CSR 10-2 [relate to the plan document which] **and 22 CSR 10-3** delineate[s] the terms of the plan established by the trustees of the Missouri Consolidated Health Care Plan [in accordance with House Bill 1574 and in accordance with Chapter 103, RSMo].

(5) Anyone wishing to obtain information may do so by contacting the plan[’s executive director] at [any of the following:]—

(C) (573) 751-8881; [or]

(D) (800) 701-8881[.];

(E) **Email:** [mchcp@mchcp.org](mailto:mchcp@mchcp.org); or

(F) **Online:** [www.mchcp.org](http://www.mchcp.org).

**AUTHORITY:** section 103.059, RSMo 2000. Original rule filed Dec. 16, 1993, effective July 30, 1994. Amended: Filed Dec. 19, 2003, effective June 30, 2004. Amended: Filed Nov. 1, 2011.

**PUBLIC COST:** This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

**PRIVATE COST:** This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box

104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 1—General Organization  
  
PROPOSED AMENDMENT**

**22 CSR 10-1.020 Public Records.** The Missouri Consolidated Health Care Plan is amending sections (1) and (3).

*PURPOSE:* This amendment changes standards of compliance with Chapter 610, RSMo, as it relates to public records of the Missouri Consolidated Health Care Plan.

(1) All public records of the Missouri Consolidated Health Care Plan, except for those records closed pursuant to the Health Insurance Portability and Accountability Act and section 610.021, RSMo, shall be open for inspection and copying at the plan's office during the plan's regular business hours[, holidays excepted]. The plan's regular business hours are 8:30 a.m. until 4:30 p.m., Central [Standard] Time. All public meetings, **records, votes, actions, and deliberation** of the Missouri Consolidated Health Care Plan shall be open to the public, other than those meetings, **records, and votes** closed pursuant to provisions of section 610.021, RSMo.

(3) When the custodian determines that requested access is not required under Chapter 610, RSMo, the custodian **upon request** shall inform the requestor of such determination citing the specific sections of Chapter 610, RSMo, under which the records are to remain closed. *[The custodian shall inform the requesting party that s/he may appeal directly to the board for access to the records requested. The appeal and all pertinent information shall be placed on the agenda for the board's next regularly scheduled meeting. If the board reverses the decision of the custodian, the board shall direct the custodian to advise the requestor and supply access to the information during the plan's regular business hours at the requestor's convenience.]*

*AUTHORITY:* section 103.059, RSMo 2000. Original rule filed Dec. 19, 2003, effective Aug. 30, 2004. Amended: Filed Nov. 1, 2011.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership  
  
PROPOSED AMENDMENT**

**22 CSR 10-2.010 Definitions.** The Missouri Consolidated Health Care Plan is deleting sections (6), (8), (9), (11), (13), (16), (19), (21), (22), (24)–(26), (29)–(32), (34), (36), (39), (42), (47), (50), (51), (53), (56)–(59), (62), (63), (65)–(67), (71), (75), (78)–(81), (83)–(86), (88)–(90), (93), (96), (99)–(104), (106), (109)–(111), (113), (114), (122), (123), (126), (127), (129), and (132)–(134); amending sections (1), (3)–(5), (9), (10), (14), (18), (23), (27), (28), (33), (37), (38), (40), (41), (43)–(46), (48), (52), (54), (55), (60), (70), (72), (73), (77), (82), (87), (94), (97), (98), (105), (112), (117), (119), (120), (124), (128), and (131); adding sections (9), (22), (24), (30), (45), (47), (56), (71), (73), and (74); and renumbering as necessary.

*PURPOSE:* This amendment changes the policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan relative to state members.

(1) Accident. An unforeseen and unavoidable event resulting in an injury *[which is not due to any fault or misconduct on the part of the person injured]*.

(3) Administrative appeal. A written request submitted by or on behalf of a member involving *[Missouri Consolidated Health Care Plan (MCHCP)] plan-related* administrative issues such as eligibility, effective dates of coverage, **and** plan changes[, etc].

(4) Adverse **benefit** determination. *[When the claims administrator reviews an admission, availability of care, continued stay, or other health care service and decides that it is not medically necessary, appropriate, or effective. Therefore, payment for the requested service is denied, reduced, or terminated.]* An adverse benefit determination means any of the following:

(A) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit based on a determination of an individual's eligibility to participate in the plan;

(B) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, or a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, investigational, or not medically necessary or appropriate; or

(C) Rescission of coverage after an individual has been covered under the plan.

(5) Allowable *[expense]* amount. *[Charges for services rendered or supplies furnished by a health plan that would qualify as covered expenses and for which the program pays in whole or in part, subject to any deductible and coinsurance amounts.]* Maximum amount on which payment is based for covered health care services. This may be called eligible expense, payment allowance, or negotiated rate. If the provider charges more than the allowed amount, the member may be balance-billed. See balance billing, section (7).

*[(6) Appeal. A written complaint submitted by or on behalf of a member regarding one (1) of the following:*

(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claim payment, handling, or reimbursement for pharmacy benefits or health care services.]

*[(7)](6) Applied behavior analysis. The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and*

functional analysis of the relationship between environment and behavior.

*[(8) Assignment. When a doctor agrees to accept Medicare's fee as full payment.]*

*[(9)] [Benefit period. The three hundred sixty-five (365) days immediately after the first date of services to treat a given condition.]*

**(7) Balance billing.** When a provider bills for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is one hundred dollars (\$100) and the allowed amount is seventy dollars (\$70), the provider may bill the member for the remaining thirty dollars (\$30). A network provider may not balance bill.

*[(10)](8) Benefits. [Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator.] Health care services covered by the plan.*

*[(11) Birthday rule. If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.]*

*[(12)](9) Board.* The board of trustees of the Missouri Consolidated Health Care Plan (MCHCP).

*[(13) Calendar year. The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.]*

*[(14)](10) Cancellation of coverage.* The *[voluntary cancellation]* ending of medical, dental, or vision coverage per a subscriber's voluntary request.

*[(15)](11) Case management.* A coordinated set of activities conducted for individual patient management of serious or complicated health conditions.

*[(16) Chiropractic services. The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health.]*

*[(17)](12) Claims administrator.* An organization or group responsible for the processing of claims and associated services for a health plan.

*[(18)](13) Coinsurance. [The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.] The member's share of the costs of a covered health care service, calculated as a percent (for example, twenty percent (20%)) of the allowed amount for the service. The member pays coinsurance plus any deductibles owed. For example, if the health insurance or plan's allowed amount for an office visit is one hundred dollars (\$100) and the member has met his/her deductible, the member's coinsurance payment of twenty percent (20%) would be twenty dollars (\$20). The health insurance or plan pays the rest of the allowed amount.*

*[(19) Comprehensive major medical. A plan that provides for cost sharing to be applied to all covered expenses, such as deductible or coinsurance.]*

*[(20)](14) Congenital defect.* Existing or dating from birth. Acquired through development while in the uterus.

*[(21) Convenient care clinics (CCCs). Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics."*

*[(22) Coordination of benefits. Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.]*

*[(23)](15) Copayment. [A set dollar amount that the covered individual must pay for specific services.] A fixed amount, for example, fifteen dollars (\$15) the member pays for a covered health care service, usually when the member receives the service. The amount can vary by the type of covered health care service.*

*[(24) Cosmetic surgery. A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than restore the anatomy and/or functions of the body which are lost or impaired due to illness or injury.*

*[(25) Covered benefits and charges. Covered benefits are a schedule of health care services payable under the plan. Covered charges are the cost for medical services eligible for consideration under the plan.*

*[(26) Custodial care. Services and supplies furnished primarily to assist an individual to meet the activities of daily living that can be provided by persons without the training of a health care provider or that do not entail and require the continuing attention of trained medical or paramedical personnel.]*

*[(27)](16) Date of service.* Date medical services are received *[or performed]*.

*[(28)](17) Deductible. [The amount of expense the member must pay before the plan begins to pay for covered services and supplies. This amount is not reimbursable by the plan.] The amount the member owes for health care services that the health plan covers before the member's health plan begins to pay. For example, if the deductible is one thousand dollars (\$1,000), the member's plan will not pay anything until s/he meets his/her one thousand dollars (\$1,000) deductible for covered health care services subject to the deductible. The deductible may not apply to all services.*

*[(29) Dependent child. Any child under the age of twenty-six (26) that is a natural child, legally adopted or placed for adoption child, or a child with one (1) of the following legal relationships with the member, so long as such legal relationship remains in effect:*

*(A) Stepchild;*

*(B) Foster child;*

*(C) Grandchild for whom the employee has legal guardianship or legal custody; and*

*(D) Other child for whom the employee is the court-ordered legal guardian.*

*1. Except for a disabled child as described in 22 CSR 10-2.010(89), a dependent child is eligible from his/her eligibility date to the end of the month he/she attains age twenty-six (26) (see paragraph 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child beyond age twenty-six*

(26)).

2. A child who is a dependent child under a guardianship of a minor will continue to be a dependent child when the guardianship ends by operation of law when the child becomes eighteen (18) years of age if such child was an MCHCP member the day before the child becomes eighteen (18) years of age.

(30) *Dependents.* The lawful spouse of the employee, the employee's child(ren), and certain survivors of employees, as provided in the plan document and these rules, for whom enrollment has been made and has been accepted for participation in the plan.

(31) *Diagnostic.* Describes a procedure to determine whether a person has a particular illness.

(32) *Diagnostic charges.* The Usual, Customary, and Reasonable (UCR) charges or the network discounted rate (NDR) for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.]

[(33)](18) *Disease management.* A program offered to [non-Medicare] members, who do not have primary Medicare coverage, to help manage certain chronic diseases.

[(34)] *Disposable supplies.* Supplies that do not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.]

[(35)](19) *Doctor/physician.* A licensed practitioner of the healing arts, as approved by the plan administrator, including:

- (A) Doctor of medicine;
- (B) Doctor of osteopathy;
- (C) Podiatrist;
- (D) Optometrist;
- (E) Chiropractor;
- (F) Psychiatrist;
- (G) Psychologist;
- (H) Doctor of dental medicine, including dental surgery;
- (I) Doctor of dentistry; or
- (J) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

[(36)] *Durable medical equipment (DME).* Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Such equipment is not covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.]

(20) *Effective date.* The date on which coverage takes effect as described in 22 CSR 10-2.020(4).

[(37)](21) *Eligibility date.* The first day a member is qualified to enroll for coverage [A/as described in 22 CSR 10-2.020(2).

(22) *Eligibility period.* The time allowed to enroll in accordance with the rules in this chapter.

[(38)](23) *Emergency medical condition.* [A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(A) Conditions placing a person's health in significant jeopardy;

(B) Serious impairment to a bodily function;

(C) Serious dysfunction of any bodily organ or part;

(D) Inadequately controlled pain; or

(E) Situations when the health of a pregnant woman or her unborn child are threatened.] The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(A) Placing a person's health in significant jeopardy;

(B) Serious impairment to a bodily function;

(C) Serious dysfunction of any bodily organ or part;

(D) Inadequately controlled pain; or

(E) With respect to a pregnant woman who is having contractions—

1. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

2. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

[(39)] *Emergency room.* The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.]

[(40)](24) *Emergency Services.* With respect to an emergency medical condition—

(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient. The term "to stabilize" means to provide such medical treatment of the condition as may be necessary to [assure] ensure, within reasonable medical probability that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility.

[(41)](25) *Employee.* A benefit-eligible person employed by the state and present and future retirees from state employment who meet the plan eligibility requirements [as prescribed by law].

[(42)] *Employee and dependent participation.* Participation of an employee and the employee's eligible dependents. Any individual eligible for participation as an employee is eligible as a dependent up to the age of twenty-six (26), except as noted in 22 CSR 10-2.020(1)(A)3.]

[(43)](26) *Employer.* The state department or agency that employs the eligible employee [as defined above].

[(44)](27) *Essential benefits.* The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(A) Ambulatory patient services—office visits, urgent care, outpatient diagnostic procedures, outpatient surgery, and outpatient hospice;

(B) Emergency services—ambulance services and emergency room services;

(C) Hospitalization—inpatient hospital benefits, inpatient surgery, transplants, and inpatient hospice;

(D) Maternity and newborn care—maternity coverage and newborn screenings;



(E) Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/chemical dependency office visits;

(F) Prescription drugs;

(G) Rehabilitative and habilitative services and devices—durable medical equipment; cardiac and pulmonary rehabilitation; outpatient physical, speech, and occupational therapy; and home health care/*palliative services*;

(H) Laboratory services—lab and */x/X-ray*;

(I) Preventive and wellness services and chronic disease management; and

(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, immunizations, preventive services, and newborn screenings.

**(28) Excluded services. Health care services that the member's health plan does not pay for or cover.**

*[(45)](29)* Executive director. The chief executive officer of the Missouri Consolidated Health Care Plan (MCHCP), who shall have charge of the offices, records, and employees of the plan, subject to the direction of the board of trustees.

*[(46)](30)* Experimental/Investigational/Unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below **and that the plan administrator determines, in the exercise of its discretion**, is considered experimental/investigational/unproven and is not eligible for coverage under the plan/. *Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community. Experimental/investigational/unproven is defined as a treatment, procedure, device, or drug that the plan administrator determines, in the exercise of its discretion]*—

(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;

(B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or

(C) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis.

**(D) Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.**

*[(47)]* First eligible. The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first eligibility period is the first thirty-one (31) days from the date of the life event.]

*[(48)](31)* Formulary. A list of U.S. Food and Drug Administration approved drugs *[covered]* and supplies developed by the pharmacy benefit manager and *[as allowed]* covered by the plan administrator.

*[(49)](32)* Generic drug. The chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but

the active ingredients must be the same for both.

*[(50)]* Group health plan. A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.

*(51) Handbook. The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference is available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2011 State Member Handbook (March 15, 2011) or online at [www.mhcp.org](http://www.mhcp.org). It does not include any later amendments or additions.]*

*[(52)](33)* Health assessment (HA). A questionnaire about a member's health and lifestyle habits required for participation in the *[wellness]* Lifestyle Ladder program.

*[(53)]* Health care benefit. Coverage under the plan to include medical, dental, vision, and pharmacy.]

*[(54)](34)* Health savings account (HSA). A tax-advantaged savings account that may be used to pay for current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. *[HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.]*

*[(55)](35)* High Deductible Health Plan (HDHP). A health plan with a higher deductible[s] than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

*[(56)]* Home health care. Skilled nursing services and other therapeutic services to persons in their homes provided by an agency certified by Medicare and licensed pursuant to state or local law.

*(57) Hospice. A public agency, private organization, or a subdivision of either that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.*

*(58) Hospice facility. A public or private organization, certified by Medicare and any other state's licensing or certifying body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility or part thereof which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.*

*(59) Hospital.*

*(A) An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic, and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24)-hour-a-day nursing service by a registered nurse (RN) on duty or call.*

*(B) An institution not meeting all the requirements of subsection (59)(A) above, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.*

*(C) An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).*

*(D) A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.*

*(E) A residential alcoholism, chemical dependency, or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction.*

*(F) In no event shall the term hospital include a skilled nursing facility or any institution or part thereof which is used primarily as a skilled nursing facility, nursing home, rest home, or facility for the aged.]*

*[(60)](36) Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered [as any other] an illness.*

*[(61)](37) Incident. A definite and separate occurrence of a condition.*

*[(62) Infertility. Any medical condition causing the inability or diminished ability to reproduce.*

*(63) Infertility services. Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.]*

*[(64)](38) Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.*

*[(65) Inpatient. Confined to a registered bed. Patient in hospital, skilled nursing facility, hospice facility, or free-standing chemical dependency treatment center.*

*(66) Life events. Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.*

*(67) Lifestyle Ladder. MCHCP's wellness program.]*

*[(68)](39) Lifetime maximum. The amount payable by a medical plan during a covered member's life for specific non-essential benefits.*

*[(69)](40) MCHCPid. An individual MCHCP member identifier used for member verification and validation.*

*[(70)](41) myMCHCP. A secure MCHCP member website that [includes coverage selection, level of coverage, an option to change a mailing address, an option to add or change an email address, an option to request an MCHCPid card, and access to other pertinent websites] allows members to review coverage selections, verify covered dependents, make coverage changes, add/change email address, and access health plan websites.*

*[(71) Medical benefits coverage. Services that are received from providers recognized by the plan and are covered benefits under the plan.]*

*[(72)](42) Medically necessary. Treatments, procedures, services, or supplies that the plan administrator determines, in the exercise of its*

*discretion—*

*(A) Are expected to be of clear clinical benefit to the patient; and*

*(B) Are appropriate for the care and treatment of the injury or illness in question; and*

*(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.*

*[(73)](43) Medicare-approved amount. The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a [doctor or] health care provider.*

**(44) Medicare assignment. When a health care provider agrees to accept the Medicare-approved amount as payment in full for claims.**

*[(74)](45) Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.*

*[(75) Network provider. A physician, hospital, pharmacy, or other health provider that is contracted with the plan or its designee.]*

**(46) Network. The facilities, providers, and suppliers the health insurer or plan has contracted with to provide health care services.**

*[(76)](47) Non-formulary. A drug not contained on the pharmacy benefit manager's list of covered drugs.*

*[(77)](48) Non-network [provider or non-participating provider. A physician, hospital, pharmacy, or other health provider that does not have a contract with the plan or its designee]. The facilities, providers, and suppliers the health plan does not contract with to provide health care services.*

*[(78) Nurse. A registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule.*

*(79) Nursing home. An institution operated, pursuant to law, primarily for custodial care or for patients recovering from illness or injury, under the supervision of a physician or registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations that are recognized under Medicare.*

*(80) Open enrollment period. A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year.*

*(81) Out-of-area. Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria.]*

*[(82)](49) Out-of-pocket maximum. [The annual limit on the amount a member must pay for covered services. Above this limit, the medical plan pays one hundred percent (100%) for covered services for the rest of the plan year.] The most the member will pay during a plan year before the plan begins to pay one hundred percent (100%) of the allowed amount. This limit never includes the member's premium, copayments, balance-billed charges, or health care services the plan does not cover.*

*[(83) Outpatient. Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.*

*(84) Outpatient observation stay. Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.*

*(85) Palliative services. Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.*

*(86) Partial hospitalization. A distinct and organized intensive ambulatory treatment service, less than twenty-four (24)-hour daily care specifically designed for the diagnosis and active treatment of a mental/nervous disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.*

*(A) Partial hospitalization programs must provide diagnostic services; services of social workers; nurses and staff trained to work with psychiatric patients; individual, group, and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions.*

*(B) The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a physician.]*

*[(87)](50) Participant. [Any employee or dependent accepted for membership in the plan.] Shall have the same meaning as the term member defined herein. See member, section (45).*

*[(88) Pharmacy benefit manager (PBM). The PBM designs, implements, and manages the overall drug benefit of the plan and processes claims payments.*

*(89) Physically or mentally disabled. A person's inability to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition.*

*(90) Physician/Doctor. A licensed practitioner of the healing arts, acting within the scope of his/her practice, as licensed under section 334.021, RSMo.]*

*[(91)](51) Plan. The program of health care benefits established by the board of trustees of the Missouri Consolidated Health Care Plan as authorized by state law.*

*[(92)](52) Plan administrator. The board of trustees of the Missouri Consolidated Health Care Plan, which is the sole fiduciary of the plan. The board has all discretionary authority to interpret its provisions and to control the operation and administration of the plan and whose decisions are final and binding on all parties.*

*[(93) Plan document. The statement of the terms and conditions of the plan as promulgated by the plan administrator in this chapter.]*

*[(94)](53) Plan year. The [calendar year beginning] period of January 1 through December 31. [This is the period during which the total amount of annual benefits is calculated. All deductibles and benefit maximums accumulate during the calendar year.]*

*[(95)](54) Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to plan members. Benefits are paid at a higher level when network providers are used.*

**(55) Premium. The monthly amount that must be paid for health insurance.**

*[(96) Preventive service. A procedure intended for avoidance or early detection of an illness.]*

*[(97)](56) Primary care physician (PCP). [A physician (usually a)An internist, family/general practitioner, or pediatrician/] who has contracted with a medical plan].*

*[(98)](57) Prior authorization. [A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service. Also known as pre-authorization or pre-notification.] A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called pre-authorization, prior approval, or precertification. The plan may require prior authorization for certain services before the member receives them, except in an emergency. Prior authorization is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request prior authorization.*

*[(99) Private duty nursing. Nursing care on a full-time basis in the member's home or home health aides.*

*(100) Proof of eligibility. Documentation required by the plan to determine a dependent's qualification for health insurance coverage.*

*(101) Proof of prior group insurance. Evidence in written form from an insurance company that provides verification of coverage for a given period of time.*

*(102) Proof of prior group coverage. If a member or his/her dependents enroll in the plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:*

- (A) Date coverage was or will be terminated;*
- (B) Reason for coverage termination; and*
- (C) List of dependents covered.*

*(103) Prostheses. An artificial extension that replaces a missing part of the body or supplements defective parts.*

*(104) Protected health information (PHI). Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.]*

*[(105)](58) Provider. A physician, hospital, medical agency, specialist, or other duly[-] licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2.010[(35)](19). Other providers include but are not limited to:*

- (A) Audiologist (AUD or PhD);*
- (B) Certified Addiction Counselor for Substance Abuse (CAC);*
- (C) Certified Nurse Midwife (CNM)—when acting within the scope of [their] his/her license in the state in which [they] s/he practices and performing a service which would be payable under this plan when performed by a physician;*
- (D) Certified Social Worker or Masters in Social Work (MSW);*
- (E) Chiropractor;*
- [(E)](F) Licensed Clinical Social Worker;*
- [(F)](G) Licensed Professional Counselor (LPC);*
- [(G)](H) Licensed Psychologist (LP);*
- [(H)](I) Nurse Practitioner (NP);*
- [(I)](J) Physician/s/ Assistant (PA);*
- [(J)](K) [Qualified] Occupational Therapist;*
- [(K)](L) [Qualified] Physical Therapist;*
- [(L)](M) [Qualified] Speech Therapist;*
- [(M)](N) Registered Nurse Anesthetist (CRNA);*
- [(N)](O) Registered Nurse Practitioner (ARNP); or*
- [(O)](P) Therapist with a PhD or Master's Degree in Psychiatry or related field.*

*[(106) Provider directory. A listing of network providers within a health plan.]*

*[(107)](59) Prudent layperson. An individual possessing an average knowledge of health and medicine.*

*[(108)](60) Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or member if the plan normally provides coverage for dependent children.*

*[(109) Reconstructive surgery. A procedure performed to restore the anatomy and/or functions of the body that are lost or impaired due to an injury or illness.*

*(110) Refractions. A record of the patient's preference for the focusing of the eyes that may then be used to purchase eyeglasses or contact lenses. It is the part of the exam that determines what prescription lens gives the patient the best possible vision.*

*(111) Rehabilitation facility. A legally operating institution, or distinct part of an institution, that has a transfer agreement with one (1) or more hospitals and is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital, and rehabilitative inpatient care and is duly licensed by the appropriate government*

*agency to provide such services.*

*(A) It does not include institutions that provide only minimal care, custodial care, ambulatory or part-time care services, or an institution that primarily provides treatment of mental/nervous disorders, substance abuse, or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission for the Accreditation of Rehabilitation Facilities.]*

*[(112)](61) Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-2.020[(7)(B)](2)(D) and is currently receiving a monthly retirement benefit from a retirement system listed in such rule.*

*[(113) Skilled nursing care. Services that must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.*

*(114) Skilled nursing facility (SNF). A public or private facility licensed and operated according to the law that provides—*

- (A) Permanent and full-time facilities for ten (10) or more resident patients;*
- (B) A registered nurse or physician on full-time duty in charge of patient care;*
- (C) At least one (1) registered nurse or licensed practical nurse on duty at all times;*
- (D) A daily medical record for each patient;*
- (E) Transfer arrangements with a hospital; and*
- (F) A utilization review plan.*

*The facility must be primarily engaged in providing continuous skilled nursing care for persons during the recovery stage of their illness or injury, and is not, other than by coincidence, a rest home for custodial care or for the aged.]*

*[(115)](62) Sound natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.*

*[(116)](63) Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.*

*[(117)](64) Specialty medications. High cost drugs that [are primarily self-injectible; sometimes oral medications] treat chronic complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis.*

*[(118)](65) State. Missouri.*

*[(119)](66) Step therapy. Designed to encourage use of therapeutically[-] equivalent, lower-cost alternatives before using more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.*

*[(120)](67) Subrogation. The substitution of one (1) "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand*

in the place of the *[participant]* member and recover the money directly from the other insurer.

*[(121)](68)* Subscriber. The employee or member who elects coverage under the plan.

*[(122)]* Surgery. Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.

*(123)* Surgery center (ambulatory). A hospital-based, hospital-sponsored, or independently-owned facility that performs surgery.]

*[(124)](69)* Survivor. A member who meets the requirements of subsection 22 CSR 10-2.020[(7)(A)](2)(D).

**(70) Terminated vested subscriber.** A member who meets the requirements of subsection 22 CSR 10-2.020(2)(D).

*[(125)](71)* Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

**(72) Tobacco.** Cigarettes, cigarette papers, clove cigarettes, cigars, smokeless tobacco, smoking tobacco, other form of tobacco products, or products made with tobacco substitute containing nicotine.

**(73) Tobacco-free.** A member has not used a tobacco product in at least the previous three (3) months and plans to remain tobacco-free in the future.

*[(126)]* Urgent care. Medically necessary services in order to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.

*(127)* Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.]

*[(128)](74)* Usual, [C]customary, and [R]reasonable [charge]. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

*[(A)]* Usual. The fee a provider most frequently charges the majority of his/her patients for the same or similar services.

*[(B)]* Customary. The range of fees charged in a geographic area by providers of comparable skills and qualifications for the same performance of similar service.

*[(C)]* Reasonable. The flexibility to take into account any unusual clinical circumstances involved in performing a particular service.

*[(D)]* A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the providers for ninety percent (90%) of the procedures reported.

*(129)* Utilization review. Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a prospective, concurrent, or retrospective basis.]

*[(130)](75)* Vendor. The current applicable third-party administrators of MCHCP benefits.

*[(131)](76)* Vested subscriber. A member who meets the requirements of subsection 22 CSR 10-2.020[(7)(B)](2)(D).

*[(132)]* Wellness participation year. Year in which members may participate in the wellness program per plan year: October 1–September 25.

*(133)* Wellness program. A voluntary program focusing on awareness, health education, and behavior change.

*(134)* Wellness premium. The monthly medical premium applied to members who successfully complete all requirements of the Lifestyle Ladder program.]

*AUTHORITY:* section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Nov. 1, 2011.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

## **Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership**

### **PROPOSED RESCISSION**

**22 CSR 10-2.020 General Membership Provisions.** This rule established the policy of the board of trustees in regard to the General Membership Provisions of the Missouri Consolidated Health Care Plan.

*PURPOSE:* This rule is being rescinded and readopted to include detailed language to clarify general membership provisions.

*AUTHORITY:* section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Rescinded: Filed Nov. 1, 2011.

*PUBLIC COST:* This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED RULE**

**22 CSR 10-2.020 General Membership Provisions**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the general membership provisions of the Missouri Consolidated Health Care Plan.*

(1) Terms and Conditions. The following rules provide the terms and conditions for membership in the Missouri Consolidated Health Care Plan (MCHCP). Members are required to provide complete, true, and accurate information to MCHCP in connection with enrollment, change, or cancellation processes, whether by online, written, or verbal communication. MCHCP may rely on, but reserves the right to audit, any information provided by members and seek recovery and/or pursue legal action to the extent members have provided incomplete, false, or inaccurate information.

(2) Eligibility Requirements.

(A) Employee Eligibility Requirements.

1. An employee may enroll in one (1) of MCHCP's plans if s/he meets the following criteria:

A. A state employee whose position is covered by the Missouri State Employees' Retirement System (MOSERS) and not covered under another retirement or benefit plan supported by state contributions or a member of the Public School Retirement System (PSRS) and employed by a state agency.

2. An employee cannot be covered as an employee and as a dependent.

(B) Dependent Eligibility Requirements.

1. An employee who is not retired may enroll eligible dependents as long as the employee is also enrolled. Eligible dependents include:

A. Spouse.

(I) If both spouses are state employees covered by MCHCP, each spouse must enroll separately.

(II) State employees eligible for coverage under the Missouri Department of Transportation, Department of Conservation, or the Highway Patrol medical plans may not enroll as a spouse under MCHCP.

(III) A state retiree may enroll as a spouse under an employee's coverage or elect coverage as a retiree.

(IV) If one spouse is a state employee with MCHCP benefits and the other is a public entity employee with MCHCP benefits, each spouse may enroll under his or her employer's plan or together under one employer's plan. The spouses cannot have coverage in both places; and

B. Children.

(I) Children may be covered through the end of the month in which they turn twenty-six (26), if they meet one of the following criteria:

(a) Natural child of subscriber or spouse;

(b) Legally adopted child of subscriber or spouse;

(c) Child legally placed for adoption of subscriber or spouse;

(d) Stepchild of subscriber or spouse;

(e) Foster child of subscriber or spouse;

(f) Grandchild for whom the covered subscriber or covered spouse has legal guardianship or legal custody;

(g) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years of age if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years of age;

(h) Newborn of a subscriber or a covered dependent;

(i) Child for whom the subscriber or covered spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or

(j) Child who is twenty-six (26) or older and is permanently disabled in accordance with subsection (5)(C), only if such child was an MCHCP member the day before the child turned twenty-six (26).

(II) A child may only be covered by one (1) parent if his/her parents are married and are both covered under an MCHCP medical plan.

(III) A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. MCHCP will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time.

(C) Changes in Dependent Status. If a covered dependent loses his/her eligibility, the subscriber must notify MCHCP within thirty-one (31) days to terminate his/her coverage effective the end of the month eligibility ceases.

(D) Retiree, Survivor, Vested, Terminated Vested, and Long-Term Disability Employee; Elected State Officials and their Employee; and Dependent Eligibility Requirements.

1. An employee may participate in an MCHCP plan when s/he retires if s/he is eligible to receive a monthly retirement benefit from either MOSERS or from PSRS for state employment.

A. To enroll or continue coverage at retirement, the employee and his/her dependents must provide all of the following:

(I) Submit a completed enrollment form within thirty-one (31) days of retirement date. Coverage is effective on retirement date;

(II) Submit a completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last two payrolls and the option to pre-pay premiums through the cafeteria plan;

(III) Submit proof of prior coverage and proof of eligibility for dependents if s/he and his/her dependents choose to enroll in an MCHCP plan at retirement and have had other insurance coverage for six (6) months immediately prior to his/her retirement; and

(IV) Submit a statement from PSRS that indicates the effective date of the subscriber's retirement if the subscriber is a PSRS retiree.

B. Employees may continue coverage on their eligible dependents into retirement.

C. If the employee's spouse is a state employee (active or

retired), s/he may transfer coverage under the plan in which his/her spouse is enrolled or from his/her spouse's coverage to his/her own coverage at any time as long as both spouses are eligible for MCHCP coverage and their coverage is continuous.

2. An enrolled terminated vested or long-term disability employee and his/her dependents will have continuous coverage into retirement unless the member submits a termination form.

3. A survivor of an active employee who is a vested subscriber and his/her dependents or a survivor of a vested subscriber who was receiving long-term disability benefits and his/her dependents from MOSERS or PSRS may continue coverage if the survivor had—

A. Coverage through MCHCP at the time of the subscriber's death; or

B. Other health insurance for the six (6) months immediately prior to employee's death. Proof of eligibility for each dependent, proof of prior group coverage (letter from previous insurance carrier or former employer with dates of effective coverage), and a list of dependents covered is required.

4. A survivor of a retired employee or long-term disability recipient may continue coverage if the survivor was covered at the time of the employee's death.

5. An employee may participate in an MCHCP plan when his/her employment with the state terminates if s/he is a vested member and is eligible for a future benefit from the MOSERS or PSRS as a state employee when s/he reaches retirement age. The employee must elect to continue coverage within thirty-one (31) days from the last day of the month in which his/her employment is terminated.

A. If a vested employee's spouse is a state employee (active or retired), the vested employee may transfer coverage under the plan in which his/her spouse is enrolled.

B. The employee and his/her dependents must meet one (1) of the following requirements to participate in an MCHCP plan as a terminated vested employee:

(I) Coverage through MCHCP since the effective date of the last open enrollment period; or

(II) Proof of prior group coverage for the six (6) months immediately prior to the termination of state employment. Proof of prior group coverage (letter from previous insurance carrier or former employer with dates of effective coverage) and list of dependents covered is required).

6. If a vested employee does not elect coverage, or if s/he cancels his/her coverage or dependent coverage, the vested employee and his/her dependents cannot enroll at a later date. The vested employee may continue coverage under the provisions of Consolidated Omnibus Budget Reconciliation Act (COBRA).

7. If any retired, survivor, terminated vested, or long-term disability employee, or his/her dependents who are eligible for coverage, elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage except as noted in paragraph (2)(D)8.

8. A long-term disability employee must be eligible for long-term disability benefits from MOSERS or PSRS and have had coverage since the effective date of the last open enrollment period.

A. The employee may continue coverage on his/her dependents or add new dependents due to a life event.

B. If the employee becomes ineligible for disability benefits, the employee and his/her dependents may continue coverage as applicable, as a terminated vested, retired, or COBRA subscriber, unless the employee returns to active state employment.

C. If coverage was not elected through MCHCP before the date of disability, the employee and his/her dependents may enroll as long as the employee and his/her dependents have had other health insurance coverage for the six (6) months immediately prior to the employee's disability. Proof of eligibility for each dependent and proof of prior group coverage (letter from previous insurance carrier or former employer with dates of effective coverage) and a list of dependents covered is required.

D. If coverage was not maintained while on disability, the employee and his/her dependents may enroll on the date the employee is eligible for retirement benefits as long as the employee and his/her dependents have had other health insurance coverage for the six (6) months immediately prior to the employee's retirement. Proof of eligibility for each dependent and proof of prior group coverage (letter from previous insurance carrier or former employer with dates of effective coverage) and a list of dependents covered is required.

E. If the employee's spouse is a state employee (active or retired), s/he may transfer coverage under the plan in which his/her spouse is enrolled.

F. If the employee wishes to be covered individually at a later date, s/he can make the change, as long as coverage is continuous.

G. If the employee returns to work, the employee and his/her state employee spouse must be covered individually.

9. A retiree, survivor, vested employee, or long-term disability employee and/or his/her dependents may continue dental and/or vision coverage into retirement without medical coverage.

10. An elected state official or his/her employees may continue coverage in an MCHCP plan if s/he is a member of the General Assembly, a state official holding a statewide office, or employed by a member of the General Assembly or a state official and his/her employment terminates because the state official or member of the General Assembly ceases to hold elected office. The elected state official or his/her employees must elect to continue coverage within thirty-one (31) days from the last day of the month in which his/her employment is terminated. The member will not later be eligible if s/he discontinues coverage at some future time.

(E) Retiree Returns to State Employment. A retiree who returns to state employment will become eligible for benefits through MCHCP and will be treated as a new employee. The employee is eligible to enroll in medical, dental, or vision coverage with any coverage level within the first thirty-one (31) days of his/her hire date.

### (3) Enrollment Procedures.

(A) Statewide Employee Benefit Employee System (SEBES). A new employee must enroll or waive coverage through SEBES at [www.sebes.mo.gov](http://www.sebes.mo.gov) within thirty-one (31) days of his/her hire date. If enrolling dependents, proof of eligibility must be submitted as defined in section (5).

#### (B) Open Enrollment.

1. An employee may elect coverage and/or change coverage levels during the annual open enrollment period if one (1) of the following occurred:

- A. Waived his/her right to insurance when first eligible;
- B. Did not enroll eligible dependents when first eligible; or
- C. Dropped his/her or dependent coverage during the year.

2. A retiree, terminated vested, long-term disability, or survivor may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If a retiree, terminated vested, long-term disability, or survivor subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in a plan during open enrollment.

#### (C) Special Enrollment Periods.

1. An employee may apply for coverage for himself/herself or for his/her dependents if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of adopted children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. An employee and his/her dependents may enroll within sixty (60) days if s/he involuntarily loses employer-sponsored coverage under one (1) of the following circumstances:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

- (III) Employer contributions toward the premiums end; or
- (IV) COBRA coverage ends.

2. A retiree, terminated vested, long-term disability, or survivor may apply for dependent coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of adopted children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A retiree, terminated vested, long-term disability, or survivor may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. MO HealthNet or Medicaid status loss. If an employee who is not retired, terminated, vested, long-term disability, survivor, or his/her dependent loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss.

4. Qualified Medical Child Support Order. If a subscriber receives a court order stating s/he is responsible for coverage of dependent, the subscriber may enroll the dependent in an MCHCP plan within sixty (60) days of the court order.

5. A survivor must submit a survivor enrollment form and a copy of the death certificate within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child or adopts a child, the dependent must be added within thirty-one (31) days of birth, adoption, or marriage.

C. If eligible dependent(s) are not enrolled when first eligible, they cannot be enrolled at a later date.

6. If an active employee has elected coverage as a dependent of another MCHCP subscriber as allowed by these rules, and the subscriber dies before coverage as a dependent goes into effect, the active employee may elect coverage as a subscriber within thirty-one (31) days of the date of death.

(4) Effective Date Provision. In no circumstances can the effective date be before the eligibility date. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

(A) Employee and Dependent Effective Dates.

1. A new employee and his/her dependent's coverage begins on the first day of the month after enrollment through SEBES.

2. Except at initial employment, an employee and his/her eligible dependents' effective date of coverage is the first of the month coinciding with or after the eligibility date. The effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP, except for newborns.

3. The effective date of coverage for a life event shall be as follows:

A. If enrollment by an employee is made before a wedding date, spouse's coverage becomes effective on the wedding date. The monthly premium is not prorated;

B. If enrollment by an employee is made within thirty-one (31) days of a wedding date, spouse's coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form and proof of eligibility;

C. If enrollment by a subscriber is made for a newborn of a member, the effective date for the newborn is the birth date. If enrollment is made by an employee due to the birth of a newborn of

the employee, the effective date for the employee and newborn is the first of the month coinciding with or after enrollment is received;

D. If enrollment by an employee is made within thirty-one (31) days after the eligibility date, for an adoption, or placement of adopted children, coverage becomes effective on the eligibility date or the first day of the calendar month coinciding with or after the date the enrollment is received; or

E. If enrollment by an employee is made due to legal guardianship of a dependent within thirty-one (31) days of guardianship effective date, the effective date for the dependent is the first day of the calendar month coinciding with or after the date the enrollment is received.

4. An employee and his/her eligible dependent(s) who elect coverage and/or change coverage levels during open enrollment shall have an effective date of January 1 of the following year.

5. An employee who transferred from a state department with coverage under another medical care plan into a state department covered by this plan, and his/her eligible dependent(s) who were covered by the other medical plan, will have coverage effective immediately if an enrollment form is submitted within thirty-one (31) days of transfer.

6. An employee who terminates all employment with the state (not simply moves from one (1) agency to another) and is rehired as a new state employee before termination of coverage, and his/her eligible dependent(s) who were covered by the plan, will have coverage effective immediately.

A. If the employee's coverage is continuous, s/he cannot increase his/her level of coverage or change plans.

B. If the employee requests coverage within the first thirty-one (31) days of hire date to begin the first of the month after his/her hire date, s/he can make changes to his/her coverage.

C. If an employee cancels coverage, s/he cannot enroll until the next open enrollment for coverage effective the following January.

7. An employee and his/her eligible dependent(s) who transfers from another state agency with MCHCP benefits to an MCHCP state agency will be transferred by the former state agency's human resource or payroll representative through eMCHCP to the new state agency. The employee must inform the former agency of the transfer in lieu of a termination. If the employee's coverage is continuous, s/he cannot increase his/her level of coverage or change plans.

8. A Qualified Medical Child Support Order is effective the first of the month coinciding with or after the form is received by the plan or date specified by the court.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents. Enrollment of a dependent is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, a letter will be sent requesting it. Except for open enrollment, documentation must be received within thirty-one (31) days of the letter date, or eligible dependent(s) will not be added. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage for the applicable dependent will terminate or never take effect. If enrolling dependents during open enrollment, proof of eligibility must be received by November 20, or eligible dependents will not be added for coverage effective the following January 1.

(A) Addition of Dependents. Required documentation should accompany the enrollment for coverage, except when adding a newborn. Failure to provide acceptable documentation with the enrollment will result in the dependent not having coverage until such proof is received, subject to the following:

1. If proof of eligibility is not received with the enrollment, such proof will be requested by letter sent to the subscriber. The enrollment will not be processed until after proof of eligibility is received. Documentation shall be received no later than thirty-one



(31) days from the date of the letter requesting such proof. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility. Failure to provide the required documentation in a timely manner will result in the dependent being ineligible for coverage until the next open enrollment period; and

2. Coverage is provided for a newborn of a member from the moment of birth. The member must notify MCHCP of the birth verbally or in writing within thirty-one (31) days of the birth date. The plan will notify the member of the steps to continue coverage. The member is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not continue unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later. Newborn proof of eligibility must be submitted within ninety (90) days of the date of birth. If proof of eligibility is not received, coverage will terminate on day ninety-one (91) from the birth date;

3. Acceptable forms of proof of eligibility are included in the following chart:

<b>Circumstance</b>	<b>Documentation</b>
Birth of dependent(s)	Government-issued birth certificate or other government-issued or legally-certified proof of eligibility listing subscriber as parent and newborn's full name and birth date
Addition of step-child(ren)	Marriage license to biological or legal parent/guardian of child(ren); and government-issued birth certificate or other government-issued or legally-certified proof of eligibility for child(ren) that names the subscriber's spouse as a parent or guardian and child's full name and birth date
Addition of foster child(ren)	Placement papers in subscriber's care
Adoption of dependent(s)	Adoption papers; Placement papers; or Filed petition for adoption; and Lists subscriber as adoptive parent
Legal guardianship of dependent(s)	Court-documented guardianship papers listing member as guardian (Power of Attorney is not acceptable)
Newborn of covered dependent	Government-issued birth certificate or legally-certified proof of eligibility for newborn listing covered dependent as parent with newborn's full name and birth date
Marriage	Marriage license or certificate recognized by Missouri law
Divorce	Final divorce decree; or Notarized letter from spouse stating s/he is agreeable to termination of coverage pending divorce or legal separation
Death	Death certificate
Loss of MO HealthNet or Medicaid	Letter from MO HealthNet or Medicaid stating who is covered and the date coverage terminates
MO HealthNet Premium Assistance	Letter from MO HealthNet or Medicaid stating member is eligible for the premium assistance program
Qualified Medical Child Support Order	Qualified medical child support order
Prior Group Coverage	Letter from previous insurance carrier or former employer stating date coverage terminated, reason for coverage termination, and list of dependents covered

(B) The employee is required to notify MCHCP on the appropriate form of the dependent's name, date of birth, eligibility date, and Social Security number.

(C) Permanently disabled children will continue to be eligible beyond age twenty-six (26) during the continuance of a permanent disability, provided the following documentation is submitted to the plan prior to the dependent's twenty-sixth birthday:

1. The Supplemental Security Income (SSI) Notice of Award from the Social Security Administration (SSA) verifying the dependent is entitled to and receiving disability benefits as of a specific date;

2. A letter from the dependent's physician describing the disability and verifying that the disability predates the SSA determination; and

3. A current benefit verification letter from the SSA confirming the dependent is still considered disabled by SSA.

(D) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. Claims will not be processed until the required information is provided. If Medicare coverage begins before turning age sixty-five (65), the member will receive a Medicare disability questionnaire. The member must submit the completed questionnaire to MCHCP for the Medicare eligibility to be submitted to the medical plan.

#### (6) Military Leave.

(A) Military Leave for an Employee who is not Retired.

1. For absences of thirty (30) days or less, coverage continues as if the employee has not been absent.

2. For absences of thirty-one (31) days or more, coverage ends unless the employee elects to pay for COBRA coverage. The agency payroll representative must notify MCHCP of the effective date of military leave.

3. If the employee is utilizing annual and/or compensatory balances and receiving a payroll, the dependent coverage is at the active employee monthly premium.

4. If the employee does not elect to continue COBRA coverage for his/her eligible dependent(s), coverage ends effective the last day of the month in which the leave begins.

5. The former employee must submit a form within thirty-one (31) days of the employee's return to work for the same level of coverage with the same plan to be reinstated. The former employee must submit a form and an official document indicating the separation date if s/he elects coverage after thirty-one (31) days of returning to work.

6. Coverage may be reinstated the first of the month in which the member returns to employment, the first of the month after return to employment, or the first of the month after the loss of military coverage.

(B) Military Leave for a Retired Member.

1. A retiree must terminate his/her coverage upon entry into the armed forces of any country by submitting a form and copy of his/her activation papers within thirty-one (31) days of his/her activation date.

2. Coverage will be terminated the last day of the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of his/her separation papers and form within thirty-one (31) days of the separation date.

3. Coverage will be reinstated as of the first of the month in which the employee returns from active duty, the first of the month after the employee returns, or the first of the month after the loss of military coverage.

4. If the retired member fails to reinstate coverage, s/he cannot enroll at a later date.

5. If the employee terminates his/her coverage, dependent coverage is also terminated.

#### (7) Termination.

(A) Termination of coverage shall occur on the last day of the calendar month coinciding with or after any of the following events, whichever occurs first:

1. Failure to make any required contribution toward the cost of coverage. If MCHCP has not received payment of premium at the end of the thirty-one (31)-day grace period, the subscriber will be retroactively terminated to the date covered by his/her last paid premium. The subscriber will be responsible for the value of services rendered after the retroactive termination date, including, but not limited to, the grace period;

2. Entry into the armed forces of any country as defined in subsection (6);

3. With respect to employees, termination of coverage shall occur upon termination of employment in a position covered by the MCHCP, except as expressly specified otherwise in this rule. Termination of employee's coverage shall terminate the coverage of dependents, except as specified in subsection (2)(D);

4. With respect to dependents, termination of coverage shall occur upon divorce or legal separation from the subscriber; or when a child reaches age twenty-six (26). A subscriber must terminate coverage for his/her spouse and stepchild(ren) at the time his/her divorce is final.

A. Subscriber shall notify MCHCP when any of subscriber's dependents cease to be a dependent as defined in this chapter. A subscriber cannot cancel coverage on his/her spouse or children during divorce or legal separation proceedings unless s/he submits a notarized letter from his/her spouse stating s/he is agreeable to termination of coverage pending divorce.

B. When a subscriber drops dependent coverage after a divorce, he/she must submit a completed form, a copy of the divorce decree, and current addresses of all affected dependents. Coverage ends on the last day of the month in which the divorce decree and completed form are received by MCHCP or, if requested, the last day of the month in which the divorce was final;

5. Death of dependent. The dependent's coverage ends on the date of death. The subscriber must submit completed form and a copy of the death certificate within thirty-one (31) days of death;

6. Termination due to a member's act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact;

7. Termination due to a member's threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP;

8. A rescission due only to non-payment of a premium, fraud, or intentional misrepresentation. MCHCP shall provide at least thirty (30) days written notice before it rescinds coverage;

9. Termination of coverage shall occur immediately upon discontinuance of the plan, subject to the plan termination provision specified in 22 CSR 10-2.080(1); and

10. If a member receives covered services after the termination of coverage, MCHCP may recover the contracted charges for such covered services from the subscriber or the provider, plus its cost to recover such charges, including attorneys' fees.

#### (8) Voluntary Cancellation of Coverage.

(A) A subscriber may cancel medical coverage, which will be effective on the last day of the month in which the form is received by MCHCP, unless the subscriber notifies MCHCP on the first calendar day of the month; then cancellation of coverage is effective the last day of the previous month.

1. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, the subscriber may only cancel medical coverage if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

(B) A subscriber may retroactively cancel coverage on his/her spouse to be effective on the last day of the month in which a divorce is final. A copy of the divorce decree must accompany the change request.

(C) If a member receives covered services after the voluntary cancellation of coverage, MCHCP may recover the contracted charges

for such covered services from the subscriber or the provider, plus its cost to recover such charges, including attorneys' fees.

(D) A subscriber may only cancel dental and/or vision coverage during the year for themselves or their dependents for one (1) of the following reasons:

1. Upon retirement; or
2. When beginning a leave of absence.

(9) Continuation of Coverage.

(A) Leave of Absence.

1. An employee on an approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify MCHCP of the leave of absence and any extension of the leave of absence by submitting the required form through eMCHCP. The employee will receive a letter, form, and bill from MCHCP to continue coverage. If the completed form and payment are returned within ten (10) days of receipt, coverage will continue and the employee will be set up on direct bill.

2. If the employee does not elect to continue coverage, coverage for the employee and his/her covered dependents is suspended effective the last day of the month in which the employee is employed.

3. If the employee fails to pay the premium due, coverage on the employee and his/her dependents terminates.

4. If the employee's spouse is a state employee (active or retired), the employee may transfer coverage under the plan in which the spouse is enrolled. If the employee wishes to be covered individually at a later date, s/he can make the change as long as coverage is continuous. When the employee returns to work, s/he and his/her spouse must be covered individually.

5. Any employee on an approved leave of absence who was a member of MCHCP when the approved leave began, but who subsequently terminated coverage in MCHCP while on leave, may recommence his/her coverage in the plan at the same level (employee only or employee and dependents) upon returning to employment directly from the leave. For coverage to be reinstated, the employee must submit a completed form within thirty-one (31) days. Coverage is reinstated on the first of the month coinciding with or after the date the form is received. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and requests reinstatement of coverage.

6. If the employee chooses to maintain employee coverage but not coverage for his/her covered dependents, the employee is eligible to regain dependent coverage upon return to work.

(B) Leave of Absence—Family and Medical Leave Act (FMLA).

1. An employee must be approved for a leave of absence under the FMLA and meet the requirements and guidelines set forth by FMLA and his/her employing agency for his/her employer to continue to pay the monthly contribution toward the employee's and his/her dependents' coverage. Coverage is continuous unless the employee chooses to cancel coverage.

2. If the employee cancels coverage, coverage ends on the last day of the month.

3. If the employee cancels coverage, the employee must submit a completed form within thirty-one (31) days of his/her return to work.

4. If the employee is unable to return to work after his/her FMLA leave ends, s/he may elect leave of absence coverage or suspend his/her coverage. If coverage is suspended at that time, s/he can enroll within thirty-one (31) days of his/her return to work.

(C) Layoff. An employee on layoff status may elect to retain eligibility to participate in the plan by paying the required contribution for a maximum of twenty-four (24) months with recertification of status at least every twelve (12) months by the employing department. The employee will receive a letter, enrollment form, and bill (if applicable) from MCHCP. If the employee chooses to continue coverage, s/he must return the enrollment form to MCHCP within ten (10) days. If the employee fails to pay the premium due, cover-

age on the employee and his/her dependents terminates. If the employee's spouse is a state employee (active or retired), the employee may transfer coverage under the plan in which his/her spouse is enrolled. If the employee wishes to be covered individually at a later date, s/he can make the change as long as coverage is continuous. If the employee returns to work with an agency covered by MCHCP, the employee and his/her spouse must be covered individually. Eligibility will terminate if the employee becomes eligible for health benefits as an employee of another employer. If coverage terminates and the employee is recalled to service, eligibility will be as a new employee.

(D) Workers' Compensation.

1. Coverage will automatically be extended to any subscriber who is receiving workers' compensation benefits. Coverage in the plan will be at the same level of coverage (employee only or employee and dependents) and the member must continue to pay the premiums that were previously deducted from his/her paycheck.

2. If the subscriber cancels coverage, coverage will end on the last day of the month in which MCHCP received the cancellation. The employee may enroll in his/her coverage within thirty-one (31) days of returning to work.

3. If the subscriber is no longer eligible for workers' compensation benefits but cannot return to work, the subscriber's status changes to leave of absence.

(E) Reinstatement after Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action, s/he will be allowed to reinstate his/her medical benefit as described below—

1. If the employee is reinstated with back pay, s/he will be responsible for paying any back contributions normally made for his/her coverage;

2. If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making the required contribution for his/her coverage;

3. If the employee does not continue coverage, s/he will be considered a new hire and may enroll in the plan of his/her choice; or

4. If the employee fails to reinstate his/her coverage, s/he cannot enroll in an MCHCP plan until the next open enrollment.

(10) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) Eligibility. In accordance with COBRA, eligible employees and their dependents may temporarily continue their coverage when coverage under the plan would otherwise end. Coverage is identical to the coverage provided under MCHCP to similarly situated employees and family members. If members cancel COBRA coverage, they cannot enroll at a later date.

1. Employees voluntarily or involuntarily terminating employment (for reasons other than gross misconduct) or receiving a reduction in the number of hours of employment may continue coverage for themselves and their covered dependent(s) for eighteen (18) months at their own expense.

2. If a subscriber marries, has a child, or adopts a child while on COBRA coverage, eligible dependents can be added to the subscriber's plan upon notification to MCHCP. The subscriber may also add eligible dependents during open enrollment.

3. Dependents may continue coverage for up to thirty-six (36) months at their own expense if the covered employee becomes eligible to Medicare.

4. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

5. A divorced spouse and dependents may continue coverage at their own expense for up to thirty-six (36) months.

6. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense.

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage, the member may continue coverage for up to twenty-nine (29) months.

8. An employee who is on military leave is eligible for continued coverage for medical and dental care for the lesser of: a) twenty-four (24) months beginning on the date the leave begins; or b) the day after the date the employee fails to apply for or return to their position of employment following leave.

9. If the eligible member has Medicare prior to becoming eligible for COBRA coverage, the member is entitled to coverage under both.

(B) Premium Payments.

1. Initial payment for continuation coverage must be received within forty-five (45) days of election of coverage.

2. After initial premium payment, MCHCP bills on the last working day of the month. There is a thirty-one (31) day grace period for payment of regularly scheduled monthly premiums.

3. Premiums for continued coverage will be one hundred two percent (102%) of the total premium for the applicable coverage level. Once coverage is terminated under the COBRA provision, it cannot be reinstated.

(C) Required Notifications.

1. The subscriber or applicable member must notify MCHCP of a divorce, legal separation, a child turning age twenty-six (26), or Medicare entitlement within sixty (60) days of the event date.

2. The human resource/payroll office of the subscriber must notify MCHCP of an employee's death, termination, or reduction of hours of employment.

(D) Election Periods.

1. When MCHCP is notified that a COBRA-qualifying event has occurred, MCHCP notifies eligible members of the right to choose continuation coverage.

2. Eligible members have sixty (60) days from the date of coverage loss or notification from MCHCP, whichever is later, to inform MCHCP that they want continuation coverage.

3. If eligible members do not choose continuation coverage within sixty (60) days of lost coverage or notification from MCHCP, coverage ends.

(E) Continuation of coverage may be cut short for any of these reasons—

1. The state of Missouri no longer provides group health coverage to any of its employees;

2. Premium for continuation coverage is not paid on time;

3. The covered employee or dependent becomes covered (after the date s/he elects COBRA coverage) under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition s/he may have;

4. The covered employee or dependent becomes entitled to Medicare after the date s/he elects COBRA coverage; or

5. The covered employee or dependent extends coverage for up to twenty-nine (29) months due to disability and there has been a final determination that the individual is no longer disabled.

(11) Missouri State Law COBRA Wrap-Around Provisions.

(A) Missouri law provides that if a member loses group health insurance coverage because of a divorce, legal separation, or the death of a spouse, the member may continue coverage until age sixty-five (65) under two (2) conditions—

1. The member continues and maintains coverage under the thirty-six (36)-month provision of COBRA; and

2. The member is at least fifty-five (55) years old when COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay the entire premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium.

(B) If continuation coverage is not chosen within the proper time frames listed below, continuation of coverage ends—

1. Within sixty (60) days of legal separation or the entry of a

decree of dissolution of marriage or prior to the expiration of a thirty-six (36)-month COBRA period, the legally separated or divorced spouse who seeks such coverage shall give MCHCP written notice of the qualifying event, including his/her mailing address;

2. Within thirty (30) days of the death of an employee whose surviving spouse is eligible for continued coverage or prior to the expiration of a thirty-six (36) month COBRA period, the human resource/payroll representative shall give MCHCP written notice of the death and the mailing address of the surviving spouse; or

3. Within fourteen (14) days of receipt of the notice, MCHCP shall notify the legally separated, divorced, or surviving spouse that coverage may be continued. The notice shall include:

A. A form for election to continue the coverage;

B. The amount of premiums to be charged and the method and place of payment; and

C. Instructions for returning the elections form by mail within sixty (60) days after MCHCP mails the notice.

(C) Continuation of coverage terminates on the last day of the month prior to the month the subscriber turns age sixty-five (65). The right to continuation coverage shall also terminate upon the earliest of any of the following:

1. The state of Missouri no longer provides group health coverage to any of its employees;

2. Premium for continuation coverage is not paid on time;

3. The date on which the legally separated, divorced, or surviving spouse becomes insured under any other group health plan;

4. The date on which the legally separated, divorced, or surviving spouse remarries and becomes insured under another group health plan; or

5. The date on which the legally separated, divorced, or surviving spouse reaches age sixty-five (65).

(12) Medicare.

(A) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(B) MCHCP's prescription drug plan is evaluated by a third party to determine whether it is creditable and considered equal to or better than Medicare Part D. The member will receive notification of the outcome from MCHCP. If MCHCP's plan is considered creditable, the member does not need to enroll in Medicare Part D and will not be penalized if s/he signs up for Part D at a later date.

(C) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the donut hole.

(13) Communications to Members.

(A) It is the member's responsibility to ensure that MCHCP has current contact information for the member and any dependent(s).

(B) A member must notify MCHCP of a change in his/her mailing or email address as soon as possible, but no later than thirty-one (31) days after the change.

(C) It is the responsibility of all members who elect to receive plan communication through email to ensure plan emails are not blocked as spam or junk mail by the member or by the member's service provider.

(D) Failure to update a mailing or email address may result in

undeliverable mail/email of important informational material, delayed or denied claims, loss of coverage, loss of continuation rights, missed opportunities relating to covered benefits, and/or liability for claims paid in error.

(14) Deadlines. Unless specifically stated otherwise, MCHCP computes deadlines by counting day one as the first day after the qualifying event. If the last day falls on a weekend or state holiday, MCHCP may receive required information on the first working day after the weekend or state holiday.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency rescission and rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Rescinded and readopted: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rule will cost state agencies or political subdivisions \$391,364,292 in the aggregate.*

*PRIVATE COST: This proposed rule will cost private entities \$117,801,060 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title:**  
**Division Title:**  
**Chapter Title:**

<b>Rule Number and Name:</b>	<b>22 CSR 10-2.020 Subscriber Agreement and General Membership Provisions</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan</b>	<b>\$391,364,292</b>

**III. WORKSHEET**

Estimated cost is the annual MCHCP contribution toward premiums for providing health care plans to enrolled state employees, retirees and dependents for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment as of August 1, 2011 (data used the CY2012 projection);
- Calendar year 2012 membership remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary, and insured premiums developed by Coventry Health Care.
- Actual claim costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.020 Subscriber Agreement and General Membership Provisions</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>97,994 individuals enrolled in MCHCP plans for CY 2012</b>	<b>Individuals enrolled in MCHCP plans for CY 2012</b>	<b>\$117,801,060</b>

**III. WORKSHEET**

Estimated cost is the annual cost for all MCHCP subscribers' premiums for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment as of August 1, 2011 (data used the CY2012 projection);
- Calendar year 2012 membership remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary, and insured premiums developed by Coventry Health Care;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.030 Contributions.** The Missouri Consolidated Health Care Plan is amending sections (1) and (2); adding sections (3)–(5); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the contributions made to the Missouri Consolidated Health Care Plan.*

(1) Total premium costs for various *[classes]* levels of employee *[participation]* coverage are based on employment status, eligibility for Medicare, and *[for]* various classifications of dependent participation *[are]* as established by the plan administrator.

(2) The employee's contribution *[by the employee]* toward total premium shall be determined by the plan administrator *[for state employees]*.

(3) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree premium is based on creditable years of service at retirement with the state. It is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by Missouri State Employees' Retirement System (MOSERS) or Public School Retirement System (PSRS) multiplied by two and one half percent (2.5%). The resulting product shall be capped at sixty-five percent (65%). After the percentage is computed, the percentage is multiplied by the PPO 600 Plan total premium for non-Medicare retirees, the percentage is multiplied by the PPO 600 Plan total premium reduced by both the tobacco-free incentive and the wellness incentive. The resulting product is the MCHCP contribution, which shall be subtracted from the total premium of the plan chosen by the retiree. The difference is the amount of the retiree contribution toward the total premium.

(4) Premium. Payroll deductions, Automated Clearing House (ACH) transactions, and/or direct bills are processed by MCHCP.

(A) Active Employee Whose Payroll Information is Housed in the SAM II Human Resource System.

1. Monthly medical premium payroll deductions are divided in half and taken by MCHCP at the end of the prior month and the fifteenth of the current month for the current month's coverage (example: September 30 and October 15 payroll deductions are taken for October medical premiums).

2. Monthly dental and vision premium payroll deductions are divided in half and taken by MCHCP on the fifteenth of the current month and the end of the current month for the current month's dental and vision coverage (example: October 15 and October 31 payroll deductions are taken for October dental and vision premiums).

A. If past premiums are owed due to timing of the receipt of the form, timing of the receipt of proof of eligibility or other circumstances, premium payroll deductions due are divided and taken in up to three (3) of the employees' future payrolls and/or additional payrolls at the discretion of MCHCP.

(B) Active Employee Whose Payroll Information is not Housed in the SAM II Human Resource System.

1. Premium payroll deductions are submitted to MCHCP monthly from the agency based on the deductions taken from the employee's payroll.

A. Medical premium payroll deduction received at the end

of the month is applied to the employee's next month's coverage (example: September 30 payroll deduction is taken for the October medical premium).

B. Dental and vision premium payroll deductions received at the end of the month are applied to the current month's dental and vision coverage (example: September 30 payroll deductions are taken for September dental and vision premiums).

C. If premiums are owed due to timing of the receipt of the change, the agency collects the premiums owed and includes the premium with the monthly deductions submitted the next month.

(C) Retirees and Survivors Premiums From Benefit Check.

1. Deduction amounts are received monthly from MOSERS based on the deductions taken from the benefit checks. Medical, dental, and vision deductions received at the end of the month pay for the next month's coverage (example: September 30 benefit check deduction is taken for October medical, dental, and vision premiums).

(D) Direct Bill for Consolidated Omnibus Budget Reconciliation Act (COBRA), Long-Term Disability, Leave of Absence, Terminated Vested, Retiree, and Survivor Members.

1. Medical, dental, and vision premiums are billed on the last working day of the month for the next month's coverage. Premiums are due fifteen (15) days from the last day of the month in which they are billed (example: bill mailed September 30 for October medical, dental, and vision premiums, premium due October 15).

2. If a member is in arrears for two (2) months of premiums and payment is not received by the fifteenth of the second month for which premiums are due, coverage is terminated due to nonpayment on the last day of the month for which full premium was received. The member will be responsible for the value of the services rendered after the retroactive termination date (example: bill sent September 30 for October premiums and no payment received; bill mailed October 31 for October and November premiums due on November 15. If payment is not received, coverage will be terminated due to nonpayment effective September 30).

(E) ACH Electronic Payment of Premiums for COBRA, Long-Term Disability, Terminated Vested, Retiree, and Survivor Members.

1. Medical, dental, and vision premiums are deducted from a subscriber's bank account on the fifth of the month to pay for the current month's coverage (example: October 5 deduction taken for October medical, dental, and vision premiums).

2. If there are insufficient funds, MCHCP will send the member a letter and bill requesting payment. If a payment is in arrears, the direct bill timeline applies as defined in paragraph (4)(D)2.

(5) Premium Payments.

(A) By enrolling in coverage under MCHCP, a member agrees that MCHCP may deduct the member's contribution toward the total premium from the member's paycheck. Payment for the first month's premium is made by payroll deduction. Double deductions may be taken to pay for the first month's coverage depending upon the date the enrollment is received and the effective date of coverage. Subsequent premium payments are deducted from the member's payroll.

(B) A retiree or survivor has a choice to have the premium deducted from his/her retirement check or survivor's benefit check, automatically withdrawn from the retiree's or survivor's bank account, or may receive a monthly bill from MCHCP.

1. If the retirement check or survivor's benefit check is not sufficient to cover the premium, the retiree's or survivor's contribution toward total premium, the contribution may be either automatically withdrawn from the retiree's or survivor's bank account, or the retiree or survivor may elect to receive a monthly bill.



2. If the retiree or survivor fails to make the necessary premium payments, coverage terminates on the last day of the month for which full premium payment was received.

3. If coverage terminates on the retiree, survivor, vested, or COBRA subscriber or his/her dependents, the subscriber cannot enroll in the plan at a later date. The subscriber is responsible for claims submitted after the termination date.

(C) If a member fails to pay premiums on the required due date, MCHCP allows a thirty-one (31)-day grace period. In the event that MCHCP has not received payment of premium at the end of the thirty-one (31)-day grace period, the member will be retroactively terminated to the date covered by the member's last paid premium. The member will be responsible for the value of the services rendered after the retroactive termination date, including, but not limited to, the grace period.

[(3)](6) Refunds of overpayments are limited to the amount overpaid during the twelve (12)-month period ending at the end of the month preceding the month during which notice of overpayment is received.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions \$391,364,292 in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities \$117,801,060 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title:**  
**Division Title:**  
**Chapter Title:**

<b>Rule Number and Name:</b>	<b>22 CSR 10-2.030 Contributions</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan</b>	<b>\$391,364,292</b>

**III. WORKSHEET**

Estimated cost is the annual cost of the MCHCP providing health care plans to all state employees and eligible retirees and dependents for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment as of August 1, 2011 (data used the CY2012 projection);
- Calendar year 2012 membership remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary, and insured premiums developed by Coventry Health Care.
- Actual costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.030 Contributions</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>97,994 individuals enrolled in MCHCP plans for CY 2012</b>	<b>Individuals enrolled in MCHCP plans for CY 2012</b>	<b>\$117,801,060</b>

**III. WORKSHEET**

Estimated cost is the annual cost for all MCHCP subscribers' premium costs for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment as of August 1, 2011 (data used the CY2012 projection);
- Calendar year 2012 membership remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary, and insured premiums developed by Coventry Health Care;
- Actual costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.045 Plan Utilization Review Policy.** The Missouri Consolidated Health Care Plan is amending section (1).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan Medical Plan.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Prior *[a]* Authorization of *[s]* Services—The claims administrator must authorize some services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. *[Participants]* **Members** who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition will not be covered.

1. The following medical services are subject to prior authorization:

A. Ambulance services for non-emergenc*y/t* use whether air or ground;

**B. Anesthesia and hospital charges for dental care for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;**

*[B./C.]* Applied behavior*[a/]* analysis for autism;

**D. Auditory brainstem implant (ABI);**

**E. Bariatric procedures;**

*[C./F.]* Cardiac and pulmonary rehabilitation after thirty-six (36) visits within a twelve (12)-week period;

*[D./G.]* Chiropractic services after twenty-six (26) visits annually;

*[E./H.]* Cochlear implant device;

**I. Chelation therapy;**

*[F./J.]* Dental care to reduce trauma and restorative services when the result of accidental injury;

*[G./K.]* Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;

*[H./L.]* Genetic testing or counseling;

*[I./M.]* Home health care and palliative services;

*[J./N.]* Hospice care;

*[K./O.]* Hospital inpatient services except for observation stays;

*[L./P.]* Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

*[M./Q.]* Nutritional counseling after three (3) sessions annually;

*[N./R.]* Orthotics over one thousand dollars (\$1,000);

*[O.]* Oxygen provided on an outpatient basis;*[/]*

*[P./S.]* Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;

**T. Procedures with codes ending in "T";**

*[Q./U.]* Prostheses over one thousand dollars (\$1,000);

*[R./V.]* Skilled nursing facility;

*[S./W.]* Surgery (outpatient)—The following outpatient surgical procedures: **cornea transplant**, potential cosmetic surgery, sleep

apnea surgery, implantable stimulators, **stimulators for bone growth**, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); *[Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth; reduction of fractures and dislocations of the jaw; excision of exostosis of jaws and hard palate; external incisions and drainage of cellulitis; incision of accessory sinuses, salivary glands, or ducts; or frenectomy];* and

*[T./X.]* Transplants including requests related to covered travel and lodging.

2. The following pharmacy services are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications*[. Drugs that treat chronic, complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis. The specialty medication requires frequent dosage adjustments, clinical monitoring, and special handling and are often unavailable at retail pharmacies. The specialty medication must be filled through the claims administrator's home delivery pharmacy provider];*

C. Medications that may be prescribed for several conditions, including some *[where]* for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. The cost of the medication exceeds nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents (\$1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications.

3. Prior authorization time frames.

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen (15)-calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least forty-five (45) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

(B) Concurrent Review—The claims administrator will monitor the medical necessity of the inpatient admission to certify the necessity of the continued stay in the hospital. *[Participants]* **Members** who have another primary carrier, including Medicare, are not subject to this provision; and

(C) Retrospective Review—Reviews conducted after services have been provided to a patient. The retrospective review **does not** include*[s]* the review of a claim that is limited to an evaluation of reimbursement levels, accuracy and adequacy of documentation or coding, or settling of payment.

**AUTHORITY:** section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Nov. 1, 2011.

**PUBLIC COST:** This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

**PRIVATE COST:** This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1)–(3); adding sections (4)–(7); and renumbering as necessary.

**PURPOSE:** This amendment changes the policy of the board of trustees in regard to the PPO 300 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

(1) Deductible amount—Network: per individual each calendar year, three hundred dollars (\$300); family *[limit]* each calendar year, six hundred dollars (\$600). Non-network: per individual each calendar year, six hundred dollars (\$600); family *[limit]* each calendar year, one thousand two hundred dollars (\$1,200).

*[(C)]* Married, active employees who are Missouri Consolidated Health Care Plan (MCHCP) subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all medical information of the family unit. Failure to report an active employee spouse when newly hired and during open enrollment will result in a separate deductible and coinsurance for both active employees.]

*[(D)](C)* During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and coinsurance. *[The newborn will not be subject to a separate deductible and coinsurance.]* The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital. If the mother is not a Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims~~[/—]~~ are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims~~[/—]~~ are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(D) Claims shall be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within one hundred (100) miles of his/her home. The *[participant]* member must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is for three (3) months. After three (3) months, the *[participant]* member must contact the claims administrator to reassess network availability.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) The family out-of-pocket maximum is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member out-of-pocket maximums may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

*[(A)](C)* Network out-of-pocket maximum for individual—one thousand two hundred dollars (\$1,200).

*[(B)](D)* Network out-of-pocket maximum for family—two thousand four hundred dollars (\$2,400).

*[(C)](E)* Non-network out-of-pocket maximum for individual—two thousand four hundred dollars (\$2,400).

*[(D)](F)* Non-network out-of-pocket maximum for family—four thousand eight hundred dollars (\$4,800).

*[(E)](G)* Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: claims for services paid at one hundred percent (100%); charges above the *[U]*/usual, *[C]*/customary, and *[R]*/reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

(4) Married, active employees who are MCHCP subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all claim and payment information of the family unit. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(5) Expenses toward the deductible and out-of-pocket maximum will not be transferred if the member changes medical plans during the plan year. When the member is enrolled in a Coventry Health Care Plan and moves to a different region, expenses toward the deductible and out-of-pocket maximum will be transferred if the member chooses an equivalent UMR plan.

(6) Copayments—set charges for the following services apply as long as network providers are utilized. Copayments do not apply to the deductible or out-of-pocket maximum.

(A) Office visit—primary care: twenty-five dollars (\$25); specialist: forty dollars (\$40); chiropractor and/or manipulation: twenty dollars (\$20); urgent care: fifty dollars (\$50) network and non-network. All lab, X-ray, or other medical services associated with the office visit apply to the deductible and coinsurance.

1. Vision office visit or refraction: forty dollars (\$40);

2. Hearing test—performed by a primary care provider: twenty-five dollars (\$25); performed by a specialist: forty dollars (\$40).

(B) Emergency room—two hundred dollars (\$200) network and non-network. Emergency room copayment includes all facility and ancillary medical services received during the emergency room visit. If a member is admitted to the hospital, the copayment is waived and all services apply to the deductible and coinsurance.

(7) Usual, customary, and reasonable fee allowed—non-network medical claims are allowed at the eighty-fifth percentile of usual, customary, and reasonable fees as determined by the vendor.

[(4)](8) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions \$175,101,065 in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities \$62,863,891 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Name:</b>	<b>22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan</b>	<b>\$ 175,101,065</b>

**III. WORKSHEET**

Estimated cost is the annual MCHCP contribution toward premiums for providing the PPO 300 Plan to state employees, retirees and dependents who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under the PPO 300 Plan as of August 1, 2011 (data used the CY2012 projection);
- Calendar year 2012 membership in the PPO 300 Plan remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary, and insured premiums developed by Coventry Health Care;
- Actual claim costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.051 PPO 300 Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>55,554 individuals enrolled in the MCHCP PPO 300 Plan for CY 2012</b>	<b>Individuals enrolled in the MCHCP PPO 300 Plan for CY 2012</b>	<b>\$62,863,891</b>

**III. WORKSHEET**

Estimated cost is the annual cost for all MCHCP subscribers' premiums for coverage under the PPO 300 Plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment in the PPO 300 Plan as of August 1, 2011 (data used for the CY2012 projection);
- Calendar year 2012 membership in the PPO 300 Plan remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary, and insured premiums developed by Coventry Health Care;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.



**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1)–(3); adding sections (4)–(6); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the PPO 600 Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.*

(1) Deductible amount—Network: per individual each calendar year, six hundred dollars (\$600); family *[limit]* each calendar year, one thousand two hundred dollars (\$1,200). Non-network: per individual each calendar year, one thousand two hundred dollars (\$1,200); family *[limit]* each calendar year, two thousand four hundred dollars (\$2,400).

*[(C)](C) Married, active employees who are Missouri Consolidated Health Care Plan (MCHCP) subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all medical information of the family unit. Failure to report an active employee spouse when newly hired and during open enrollment will result in a separate deductible and coinsurance for both active employees.]*

*[(D)](C) During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and coinsurance. [The newborn will not be subject to a separate deductible and coinsurance.] The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if he/she is transferred to another hospital. If the mother is not a Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.*

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims~~[/—]~~ are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims~~[/—]~~ are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(D) Claims shall be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within one hundred (100) miles of his/her home. The *[participant] member* must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is for three (3) months. After three (3) months, the *[participant] member* must contact the claims administrator to reassess network availability.

(3) Out-of-pocket maximum—the maximum amount payable by the *[participant] member* before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) The family out-of-pocket maximum is an aggregate of

applicable charges received by all covered members of the plan. Any combination of covered family member out-of-pocket maximums may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

*[(A)](C) Network out-of-pocket maximum for individual—one thousand five hundred dollars (\$1,500).*

*[(B)](D) Network out-of-pocket maximum for family—three thousand dollars (\$3,000).*

*[(C)](E) Non-network out-of-pocket maximum for individual—three thousand dollars (\$3,000).*

*[(D)](F) Non-network out-of-pocket maximum for family—six thousand dollars (\$6,000).*

*[(E)](G) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: claims for services paid at one hundred percent (100%); charges above the *[U]*usual, *[C]*customary, and *[R]*reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.*

(4) Married, active employees who are MCHCP subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all claim and payment information of the family unit. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

(5) Expenses toward the deductible and out-of-pocket maximum will not be transferred if the member changes medical plans during the plan year. When the member is enrolled in a Coventry Health Care Plan and moves to a different region, expenses toward the deductible and out-of-pocket maximum will be transferred if the member chooses an equivalent UMR plan.

(6) Usual, customary, and reasonable limit fee allowed—non-network medical claims are processed at the eighty-fifth percentile of usual, customary, and reasonable fees as determined by the vendor.

*[(4)](7) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions \$140,839,257 in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities \$37,333,947 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 2**

<b>Rule Number and Name:</b>	<b>22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan</b>	<b>\$ 140,839,257</b>

**III. WORKSHEET**

Estimated cost is the annual MCHCP contribution toward premiums for providing the PPO 600 Plan to state employees, retirees and dependents who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under the PPO 600 Plan as of August 1, 2011 (data used the CY2012 projection);
- Calendar year 2012 membership in the PPO 600 Plan remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary, and insured premiums developed by Coventry Health Care;
- Actual claim costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>41,385 individuals enrolled in the MCHCP PPO 600 Plan for CY 2012</b>	<b>Individuals enrolled in the MCHCP PPO 600 Plan for CY 2012</b>	<b>\$37,333,947</b>

**III. WORKSHEET**

Estimated cost is the annual MCHCP subscribers' premiums for coverage under the PPO 600 Plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment in the PPO 600 Plan as of August 1, 2011 (data used for the CY 2012 projection);
- Calendar year 2012 membership in the PPO 600 Plan remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary, and insured premiums developed by Coventry Health Care;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is deleting section (5); amending sections (1)–(3) and (6); adding sections (4), (8), and (9); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the High Deductible Health Plan benefit provisions and covered charges of the Missouri Consolidated Health Care Plan.*

(1) Deductible amount—Network: per individual each calendar year, one thousand two hundred dollars (\$1,200); family *[limit]* each calendar year, two thousand four hundred dollars (\$2,400). Non-network: per individual each calendar year, two thousand four hundred dollars (\$2,400); family *[limit]* each calendar year, four thousand eight hundred dollars (\$4,800).

**(A) Network and non-network deductibles are separate. Expenses cannot be shared or transferred between network and non-network benefits.**

*[(A)](B)* The family deductible *[must be met before claim payments begin, applicable when two (2) or more family members are covered]* applies when two (2) or more family members are covered. The family deductible must be met before claim payment begins for any covered member.

*[(B)]* If both a husband and wife are state employees covered by Missouri Consolidated Health Care Plan (MCHCP) and they both enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), they must each have a separate HSA. The maximum contribution MCHCP will make for the family is one thousand four hundred dollars (\$1,400) regardless of the number of HSAs or the number of children covered under the HDHP for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a seven-hundred-dollar (\$700) contribution to each spouse, to total one thousand four hundred dollars (\$1,400).

*(C)* Married, active employees who are MCHCP subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all medical information of the family unit. Failure to report an active employee spouse when newly hired and during open enrollment will result in a separate deductible and coinsurance for both active employees.]

*[(D)](C)* During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and *[coinsurance]* out-of-pocket maximum. *[The newborn will not be subject to a separate deductible and coinsurance.]* The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital. **If the mother is not a Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.**

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of

the calendar year once the out-of-pocket maximum is reached.

(A) Network claims/—/ are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims/—/ are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(D) Claims shall be paid at eighty percent (80%) if the subscriber requires covered services that are not available through network provider within one hundred (100) miles of his/her home. The *[participant]* member must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is for three (3) months. After three (3) months, the *[participant]* member must contact the claims administrator to reassess network availability.

(3) Out-of-pocket maximum—the maximum amount payable by the *[participant]* member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

**(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.**

**(B) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before claim payment begins for any covered member.**

*[(A)](C)* Network out-of-pocket maximum for individual—two thousand four hundred dollars (\$2,400).

*[(B)](D)* Network out-of-pocket maximum for family—four thousand eight hundred dollars (\$4,800).

*[(C)](E)* Non-network out-of-pocket maximum for individual—four thousand eight hundred dollars (\$4,800).

*[(D)](F)* Non-network out-of-pocket maximum for family—nine thousand six hundred dollars (\$9,600).

*[(E)](G)* Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: claims for services paid at one hundred percent (100%); charges above the *[U]*usual, *[C]*customary, and *[R]*reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

**(4) Married, active employees who are MCHCP subscribers need to meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must report the other spouse as eligible for coverage when newly hired and during the open enrollment process. Each subscriber will have access to all claim and payment information of the family unit. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.**

*[(4)](5)* Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

*[(5)]* Pharmacy benefits are subject to the HDHP deductible and coinsurance.]

(6) A member does not qualify for the HDHP if *[they are]* s/he is covered under or enrolled in any of the following types of insurance plans or programs:

(E) The *[participant]* member has veteran's benefits that have been used within the past three (3) months.

**(8) Health Savings Account (HSA) Contributions.**

**(A) To receive contributions from MCHCP, the employee must open a HSA with the bank designated by MCHCP.**

(B) MCHCP will make a twenty-five dollar (\$25) monthly contribution to the employee's HSA account to total three hundred dollars (\$300) annually. If a family is enrolled, MCHCP will make a fifty dollar (\$50) contribution to the employee's HSA account to total six hundred dollars (\$600) annually.

(C) If both a husband and wife are state employees covered by MCHCP and they both enroll in a HDHP with HSA, they must each have a separate HSA. The maximum contribution MCHCP will make for the family is six hundred dollars (\$600) regardless of the number of HSAs or the number of children covered under the HDHP for either parent. MCHCP will consider married state employees as one (1) family and will not make two (2) family contributions to both spouses or one (1) family contribution and one (1) individual contribution. MCHCP will make a three hundred dollar (\$300) contribution to each spouse to total six hundred dollars (\$600).

(9) Usual, customary, and reasonable fee allowed—non-network medical claims are processed at the eighty-fifth percentile of usual, customary, and reasonable fees as determined by the vendor.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2008, effective Jan. 1, 2009, expired June 29, 2009. Original rule filed Dec. 22, 2008, effective June 30, 2009. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions \$4,258,674 in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities six hundred ninety-two thousand five hundred fifty dollars (\$692,550) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 2**

<b>Rule Number and Name:</b>	<b>22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan</b>	<b>\$ 4,258,674</b>

**III. WORKSHEET**

Estimated cost is the annual MCHCP contribution toward premiums and health saving accounts for providing the High Deductible Health Plan (HDHP) to state employees, retirees and dependents who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under the HDHP as of August 1, 2011 (data used the CY2012 projection);
- Calendar year 2012 membership in the HDHP remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Actual claim costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>994 individuals enrolled in the MCHCP HDHP for CY 2012</b>	<b>Individuals enrolled in the MCHCP HDHP for CY 2012</b>	<b>\$692,550</b>

**III. WORKSHEET**

Estimated cost is the annual MCHCP subscribers' premiums for coverage under the High Deductible Health Plan (HDHP) for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment in the HDHP as of August 1, 2011 (data used for the CY2012 projection);
- Calendar year 2012 membership in the HDHP remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1)–(3).

*PURPOSE:* This amendment changes the policy of the board of trustees in regard to the Medicare Supplement Plan Benefit Provisions and Covered Charges for members of the Missouri Consolidated Health Care Plan.

(1) Eligibility—Subscribers and dependents covered in this plan must be enrolled in Medicare[, and the subscribers must be eligible to receive a monthly retirement benefit from either the Missouri State Employees' Retirement System (MOSERS) or from the Public School Retirement System (PSRS), based on years of service.] **as their primary coverage.** A subscriber may enroll in this plan when first eligible for Medicare or during open enrollment.

(2) Available services—The Medicare Supplement Plan includes the following benefits relating to Medicare Parts A and B eligible benefits after the applicable Medicare deductibles are met:

(A) Inpatient hospitalization—[coverage for coinsurance for day/ covers days sixty-one (61) through day [ninety (90)] **one hundred fifty (150) and three hundred sixty-five (365) additional days after Medicare coverage ends;**

[(B) Inpatient hospitalization—coverage for coinsurance for lifetime reserve days ninety-one (91) through one hundred fifty (150);

(C) Inpatient hospitalization—covers Medicare Part A coinsurance plus coverage for three hundred sixty-five (365) additional days after Medicare coverage ends;]

[(D)](B) Medical costs—covers Medicare Part B coinsurance;

[(E)](C) Blood—covers the first three (3) pints of blood each year; and

[(F)](D) Hospice—[coverage for the five percent (5%) coinsurance for Medicare-approved charges for inpatient respite care and five percent (5%) coinsurance up to a five-dollar (\$5) coinsurance maximum for prescription pain medications] covers coinsurance for outpatient drugs and inpatient respite care; member may need to meet Medicare's requirements, including a doctor's certification or terminal illness.

(3) Limitations and exclusions—

(A) Medicare Parts A and B deductibles;

[(A)](B) Charges above Medicare allowed amounts are the member's responsibility; and

[(B)](C) Limitations and exclusions follow Medicare guidelines.

*AUTHORITY:* section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Amended: Filed Nov. 1, 2011.

*PUBLIC COST:* This proposed amendment will cost state agencies or political subdivisions fifty-six thousand six hundred ninety-eight dollars (\$56,698) in the aggregate.

*PRIVATE COST:* This proposed amendment will cost private entities fifty-five thousand five hundred thirty-eight dollars (\$55,538) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.



**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Name:</b>	<b>22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

<b>Affected Agency or Political Subdivision</b>	<b>Estimated Cost of Compliance in the Aggregate</b>
<b>Missouri Consolidated Health Care Plan</b>	<b>\$ 56,698</b>

**III. WORKSHEET**

Estimated cost is the annual MCHCP contribution toward premiums for providing the Medicare Supplement Plan to state retirees and dependents who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under the Medicare Supplement Plan as of August 1, 2011 (data used the CY2012 projection);
- Calendar year 2012 membership in the Medicare Supplement Plan remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Actual claim costs will vary based upon actual utilization of services.

## FISCAL NOTE PRIVATE COST

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

## **II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>61 individuals enrolled in the MCHCP Medicare Supplement Plan for CY 2012</b>	<b>Individuals enrolled in the MCHCP Medicare Supplement Plan for CY 2012</b>	<b>\$55,538</b>

## **III. WORKSHEET**

Estimated cost is the annual MCHCP subscribers' premiums for coverage under the Medicare Supplement Plan for calendar year 2012.

## **IV. ASSUMPTIONS**

- Total enrollment in the Medicare Supplement Plan as of August 1, 2011 (data used for the CY2012 projection);
- Calendar year 2012 membership in the Medicare Supplement Plan remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED RESCISSION**

**22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges.** This rule established the policy of the board of trustees in regard to the medical plan benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded and readopted to include detailed language to clarify medical plan benefit provisions and covered charges.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the Code of State Regulations. Emergency rescission filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Rescinded: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED RULE**

**22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the medical plan benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan.*

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.*

(1) Benefit Provisions Applicable to the PPO 300 Plan, PPO 600 Plan, and High Deductible Health Plan (HDHP). Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(2) Covered Charges Applicable to the PPO 300 Plan, PPO 600 Plan, and HDHP.

(A) Covered charges are only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a non-covered service. This includes covered services:

1. Prescribed by an appropriate health care provider for the therapeutic treatment of injury or sickness;
2. To the extent they do not exceed any limitation or exclusion; and
3. For not more than the usual, customary, and reasonable charge, as determined by the claims administrator for the services provided, will be considered covered charges.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, reasonable, and customary, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and
2. The usual, customary, and reasonable charges in the area in which services and/or supplies are provided.

(C) A physician visit to seek a second opinion is a covered service.

(D) Services in a Country Outside of the United States. Emergency room and urgent care medical services are covered at the network benefit. All other non-emergency services are covered at the non-network benefit.

(E) Medical plan benefits, limitations, and exclusions effective January 1, 2012, are incorporated by reference into this rule and are available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, or online at [www.mchcp.org](http://www.mchcp.org). This rule does not include any later amendments or additions.

(F) Plan benefits for the PPO 300 Plan, PPO 600 Plan, and HDHP are as follows:

1. Allergy testing and immunotherapy. Allergy testing and allergy immunotherapy is covered for members with clinically significant allergic symptoms. No coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning;

2. Ambulance service. Ambulance transport services involve the use of specially designed and equipped vehicles to transport ill or injured individuals. Ambulance transportation by ground to the nearest appropriate facility is covered when medically necessary and other means of transportation would be contraindicated. This can include emergent and non-emergent, yet medically necessary situations. Ambulance transportation by air to the nearest appropriate facility is covered when medically necessary and only if the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Use of air ambulance or medical helicopter service from any country returning to the U.S. is excluded;

3. Applied behavior analysis for autism. For children younger than age nineteen (19), the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior are covered with a forty thousand dollar (\$40,000) annual limit. The annual limit may be exceeded, upon prior authorization by the medical plan, if services beyond the annual limit are medically necessary;

4. Bariatric surgery. Open or laparoscopic Roux-en-Y gastric bypass (RYGB), open or laparoscopic sleeve gastrectomy (SG), open or laparoscopic biliopancreatic diversion (BPD) with or without duodenal switch (DS), or laparoscopic adjustable silicone gastric banding

(LASGB) are covered when specific health criteria are met;

5. Birth control devices and injections. Birth control is any method used to prevent pregnancy. Food and Drug Administration (FDA)-approved birth control devices and injections are covered when administered in a physician's office;

6. Cancer trials. Coverage for routine patient care costs incurred as the result of a Phase II, III, or IV clinical trial that is approved by an appropriate entity and is undertaken for the purposes of the prevention, early detection, or treatment of cancer. Coverage includes routine patient care costs incurred for drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's condition. Coverage includes reasonable and medically-necessary services needed to administer the drug or use the device under evaluation in the clinical trial;

7. Cardiac rehabilitation. Coverage for an electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) as medically necessary when it is individually prescribed by a physician and a formal exercise stress test is completed following the event and prior to the initiation of the program. Up to thirty-six (36) visits are covered within a twelve (12)-week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

8. Chelation therapy. Chelation therapy agents covered for FDA-approved indication(s) and associated condition(s). Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit are explicitly excluded under MCHCP's benefit plan. Therefore, treatment of metal toxicity that occurs as a result of occupational exposure is not covered;

9. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered. Up to twenty-six (26) visits covered annually. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

10. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation is covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device.

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

11. Dental care/accidental injury. Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors, or cysts. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization. General anesthesia is covered when dental care is provided in a participating or non-participating hospital or surgical center;

12. Durable medical equipment (DME)/medically necessary disposable supplies. DME is covered when the equipment is ordered by a physician to treat an injury or sickness (illness). DME includes, but is not limited to, insulin pumps, oxygen, augmentative communication devices, and manual and powered mobility devices. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, colostomy and ureterostomy bags and prescription compression stockings, are cov-

ered. Prescription compression stockings are limited to two (2) pairs or four (4) individual stockings per plan year. Non-reusable disposable supplies, including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered. Repair and replacement of DME is covered when—

A. Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

B. Routine wear and tear of the equipment renders it non-functional and the member still requires the equipment; or

C. The physician provides documentation that the condition of the member changes or if growth-related;

13. Emergency room services. An emergency medical condition is defined as the manifestation of acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If admitted to hospital, may be required to transfer to network facility for maximum benefit;

14. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

15. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when associated with systemic conditions that are significant enough to result in severe circulatory insufficiency and/or areas of desensitization in the lower extremities and service is provided by a qualified health provider. Foot care is considered routine in nature and not medically necessary in the absence of systemic disease that has resulted in severe circulatory insufficiency and/or areas of desensitization in the lower extremities;

16. Genetic counseling. The National Society of Genetic Counselors defines genetic counseling as: "The process of helping people understand and adapt to the medical, psychological, and familial implications of genetic contributions to disease." Pre-test and post-test genetic counseling with a physician or a licensed or certified genetic counselor covered as medically necessary for an individual recommended for covered heritable genetic testing;

17. Genetic testing. No coverage for testing based on family history alone. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

A. The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

B. The result of the test will directly impact the treatment being delivered to the member;

C. The testing method is considered scientifically valid for identification of a genetically linked heritable disease; and

D. After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

18. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

19. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars (\$200), and the lifetime maximum is three thousand two hundred dollars (\$3,200);

20. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars (\$1,000).

B. Programmable: two thousand dollars (\$2,000).

C. Digital: two thousand five hundred dollars (\$2,500).

D. Bone Anchored Hearing Aid (BAHA): three thousand five hundred dollars (\$3,500);

21. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by physician;

22. Home health care. Skilled home health care is covered for members who are homebound because of illness or injury (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent, or of short duration, or to receive medical care); services must be performed by a registered nurse or licensed practical (vocational) nurse, licensed therapist, or a registered dietitian;

23. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care which is directed mostly toward palliative care and symptom management) and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week;

24. Hospital (includes inpatient, outpatient, and surgical centers). The following benefits are covered:

A. Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

B. Intensive care unit room and board;

C. Surgery, therapies, and ancillary services—

(I) Cornea transplant-travel and lodging are not covered for cornea transplant;

(II) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(III) Sterilization for the purpose of birth control is covered;

(IV) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(V) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19); and

(VI) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

D. Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(I) Member must be ill in more than one area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(II) The member's mental health disorder must be treatable in an inpatient facility;

(III) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region; and

(IV) The attending physician must be a psychiatrist. If the

admitting physician is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board eligible or board certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of mental health disorders;

E. Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multi-disciplinary services not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment;

F. Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and

G. Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(I) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(II) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(III) A state-licensed psychologist;

(IV) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(V) Licensed professional counselor;

25. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom, and to detect or monitor a condition;

26. Maternity coverage. Prenatal and postnatal care is covered. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two (2)-visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility;

27. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian), up to three (3) sessions annually with a registered dietitian, with physician order. The maximum may be exceeded for an additional three (3) sessions, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program because they are not considered to be medically necessary. Conditions for which nutritional evaluation and counseling are not considered to be medically necessary include, but are not

limited to, the following:

- A. Attention-deficit/hyperactivity disorder (ADHD);
- B. Chronic fatigue syndrome (CFS);
- C. Idiopathic environmental intolerance (IEI); or
- D. Asthma;

28. Nutritional therapy. Nutritional therapy is covered when it is the sole source of nutrition or a significant percentage of the daily caloric intake; is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder; is prescribed by a physician; is necessary to sustain life or health; and requires ongoing evaluation and management by a licensed healthcare provider;

29. Office visit. Member encounter with a health care or mental health care/chemical dependency provider in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan being provided, including non-specialty infusions and injections. Specialty injections NEUPOGEN® (Filgrastim) and Neulasta® (Pegfilgrastim) are covered under the medical plan when the treating physician deems it medically necessary to be administered in the physician's office rather than as a self-injectable;

30. Orthotics. Therapeutic shoes, inserts, and/or modifications to therapeutic shoes; thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis; helmets-covered when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living; cranial orthosis for plagiocephaly, cervical orthosis, hip orthosis, knee orthosis, and ankle-foot/knee-ankle-foot orthoses (AFO) are covered;

31. Physical, speech, and occupational therapy and rehabilitation services (outpatient). Up to sixty (60) combined visits allowed per incident if showing significant improvement. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

#### 32. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Annual physical exams (well man, woman, and child) and routine lab and X-ray services ordered as part of the annual exam. One exam (1) per calendar year is covered. For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

#### F. Cancer screenings—

(I) Mammograms—one exam per year, no age limit;

(II) Pap smears—one per year, no age limit;

(III) Prostate—one per year, no age limit; and

(IV) Colorectal Screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive regardless of diagnosis. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Flu vaccination (influenza)—The seasonal flu vaccine is covered under the preventive care benefit. When shot is obtained out of network, member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive up to twenty-five dollars (\$25). Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.

(I) Standard or preservative-free injectable influenza vaccine is a medically necessary preventive service for members when

influenza immunization is recommended by the member's doctor.

(II) Intradermal influenza vaccine is a medically necessary preventive service for members eighteen (18) to sixty-four (64) years of age when influenza immunization is recommended by the member's doctor.

(III) Intranasally administered influenza vaccine is a medically necessary alternative to injectable influenza vaccine for immunocompetent healthy persons two (2) to forty-nine (49) years of age when influenza immunization is recommended by the member's doctor;

33. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition, or if growth-related;

34. Pulmonary rehabilitation. Up to thirty-six (36) visits within a twelve (12)-week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and postoperative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) and/or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake ( $\text{VO}_{2\text{max}}$ ) equal to or less than twenty (20) ml/kg/min, or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

35. Skilled nursing facility. Benefits are limited to one hundred twenty (120) days per calendar year;

36. Stimulators (for bone growth). Implantable bone growth stimulators covered as an outpatient surgery, nonimplantable bone growth stimulator covered under durable medical equipment.

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)). Medically-necessary DME to accelerate healing of fresh fractures, fusions, or delayed unions.

B. Electrical stimulation: direct current electrical bone-growth stimulator medically necessary for delayed unions of fractures or failed arthrodesis, non-unions, failed fusions, and congenital pseudarthrosis and members who are at high risk for spinal fusion failure;

37. Transplants. When neither experimental nor investigational and medically necessary: bone marrow, kidney, liver, heart, lung, pancreas, intestinal, or any combination are covered under the transplant

benefits. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements. Travel, if approved, is limited to ten thousand dollars (\$10,000) maximum per transplant.

A. Network. Includes travel and lodging allowance for recipient and his/her immediate family travel companion (younger than nineteen (19), both parents) if transplant facility is more than one hundred (100) miles from residence.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to [www.gsa.gov](http://www.gsa.gov) for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Transplant benefits at a non-network facility. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals not covered. Non-network facility charges and payments for transplants are limited to the following maximum only:

(I) Allogenic bone marrow—one hundred forty three thousand dollars (\$143,000);

(II) Autologous Bone Marrow—one hundred twenty-one thousand dollars (\$121,000);

(III) Heart—one hundred twenty-eight thousand dollars (\$128,000);

(IV) Heart and lung—one hundred thirty-three thousand dollars (\$133,000);

(V) Lung—one hundred fifty-one thousand dollars (\$151,000);

(VI) Kidney—Fifty-four thousand dollars (\$54,000);

(VII) Kidney and pancreas—ninety-seven thousand dollars (\$97,000); and

(VIII) Liver—one hundred fifty-three thousand dollars (\$153,000);

38. Urgent care. Services to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician's office but not severe enough to require treatment in a hospital emergency department; and

39. Vision. Routine exam (including refractions). One (1) per covered person per calendar year.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the Code of State Regulations. Emergency rescission and rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Rescinded and readopted: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rule will cost state agencies or political subdivisions \$391,364,292 in the aggregate.*

*PRIVATE COST: This proposed rule will cost private entities \$117,801,060 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 2**

<b>Rule Number and Name:</b>	<b>22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan</b>	<b>\$391,364,292</b>

**III. WORKSHEET**

Estimated cost is the annual MCHCP contribution toward premiums for providing health care plans to enrolled employees, retirees and dependents for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment as of August 1, 2011 (data used the CY2012 projection);
- Calendar year 2012 membership remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary.
- Actual claim costs will vary based upon actual utilization of services.



**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>97,994 individuals enrolled in MCHCP plans for CY 2012</b>	<b>Individuals enrolled in MCHCP plans for CY 2012</b>	<b>\$117,801,060</b>

**III. WORKSHEET**

Estimated cost is the annual MCHCP subscribers' premiums for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment as of August 1, 2011 (data used the CY2012 projection);
- Calendar year 2012 membership remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary, and insured premiums developed by Coventry Health Care;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and HDHP Limitations.** The Missouri Consolidated Health Care Plan is deleting sections (4), (9), (13), (18), (21), (27), (31), (43), (48)–(50), (52), (55), (57)–(59), (62)–(64), and (66)–(68); amending sections (5), (19), (26), (35), (38), (39), (44), (47), (61), and (65); adding sections (8) and (45); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the PPO 300 Plan, PPO 600 Plan, and HDHP Limitations of the Missouri Consolidated Health Care Plan.*

*[(4)] Allergy services—no coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.]*

*[(5)](4) Alternative therapies—including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback[, and other forms of alternative therapy with the exception of aquatic therapy performed by a physical therapist].*

*[(6)](5) Assistant surgeon services—not covered unless determined to meet the clinical eligibility for coverage under the plan.*

*[(7)](6) Athletic trainer services—services by a licensed athletic trainer not covered.*

*[(8)](7) Autopsy.*

*[(9) Bariatric procedures—not covered except for members who have undergone bariatric procedures before December 31, 2010, that were approved by the medical plan will receive follow-up care until December 31, 2011. Revisions and corrections of bariatric procedures are covered only when the revision is used to treat life-threatening complications (e.g., wound infection, abscess, dehiscence, gastric leaking, and embolism).]*

**(8) Birthing center.**

*[(10)](9) Blood donor expenses—not covered.*

*[(11)](10) Blood pressure cuffs/monitors—not covered.*

*[(12)](11) Blood storage—not covered, including whole blood, blood plasma, and blood products.*

*[(13) Breast augmentation mammoplasty—not covered unless associated with breast surgery following a medically necessary mastectomy incurred secondary to active disease.]*

*[(14)](12) Care received without charge.*

*[(15)](13) Charges resulting from the failure to appropriately cancel a scheduled appointment.*

*[(16)](14) Childbirth classes.*

*[(17)](15) Comfort and convenience items.*

*[(18) Cosmetic, plastic, reconstructive, or restorative surgery—unless medically necessary to repair a functional disorder caused by disease or injury, or congenital defect or abnormality (for a participant under the age of nineteen (19)), or to restore symmetry following a mastectomy.]*

*[(19)](16) Custodial or domiciliary care—includes services and supplies that assist members in the activities of daily living [like] such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be provided by persons without the training of a health care provider.*

*[(20)](17) Dental—treatment must be initiated within sixty (60) days of accident. Limited to treatment of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease. Oral surgery is covered only when medically necessary as a direct result from injury, tumors, or cysts. Dental care, including oral surgery, as a result of poor dental hygiene is not covered. Extractions of bony or partial bony impactions are excluded.*

*[(21) Durable medical equipment and disposable supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose. Over-the-counter medications and supplies. Prescription compression stockings are limited to two (2) pairs of four (4) individual stockings per plan year.]*

*[(22)](18) Educational or psychological testing—not covered unless part of a treatment program for covered services.*

*[(23)](19) Examinations requested by a third party.*

*[(24)](20) Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.*

*[(25)](21) Exercise equipment.*

*[(26)](22) Experimental services or investigational services—experimental or investigational services, procedures, supplies, or drugs as determined by the claims administrator are not covered[, except clinical trials for cancer treatment as specified by law].*

*[(27) Eye glasses and contact lenses—charges incurred in connection with the fitting of eye glasses or contact lenses except for initial placement immediately following cataract surgery.]*

*[(28)](23) Eye services—health services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.*

*[(29)](24) Services obtained at a government facility—not covered if care is provided without charge.*

*[(30)](25) Gender reassignment—health services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.*

*[(31) Hair analysis, wigs, and hair transplants—services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also, hairstyling wigs, hairpieces, and hair prostheses, including those ordered by a participating provider, are not covered. Such items and services are not*

*covered except for members ages eighteen (18) and under with alopecia as specified by law. Subject to two hundred dollar (\$200) annual maximum and three thousand two hundred dollar (\$3,200) lifetime maximum.]*

[(32)](26) Health and athletic club membership—including costs of enrollment.

[(33)](27) Home births.

[(34)](28) Immunizations requested by third party or for travel.

[(35)](29) Infertility treatment. **Services are covered to diagnose the condition.**

[(36)](30) Level of care, if greater than is needed for the treatment of the illness or injury.

[(37)](31) Long-term care.

[(38)](32) Medical care and supplies—not **covered** to the extent that they are payable under—

(A) A plan or program operated by a national government or one (1) of its agencies; or

(B) Any state's cash sickness or similar law, including any group insurance policy approved under such law.

[(39)](33) Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the *[participant]* **member**, such as a spouse, parent, child, sibling, or brother/sister-in-law.

[(40)](34) Military service connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

[(41)](35) Never events—twenty-eight (28) occurrences on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting. They are defined as adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.

[(42)](36) Nocturnal enuresis alarm.

[(43)] *Non-network providers—subject to higher deductible and non-network coinsurance.]*

[(44)](37) Not medically necessary services[—*with the exception of preventive services*].

[(45)](38) Orthognathic surgery.

[(46)](39) Orthoptics.

[(47)](40) Other charges—no coverage for charges that would not be incurred if the subscriber was not covered. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan. Miscellaneous service charges—telephone consultations, charges for failure to keep scheduled appointment *[(unless the scheduled appointment was for a mental health service)]*, or any late payment charge.

[(48)] *Outpatient birthing centers.*

(49) *Over-the-counter medications—except for insulin and drugs recommended by the U.S. Preventive Services Task*

*Force (Categories A and B) as prescribed by a physician and included on the formulary through the pharmacy benefit.*

(50) *Over-the-counter supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose.]*

[(51)](41) Physical fitness.

[(52)] *Physical, speech, and occupational therapy—health services and associated expenses for development delay. Treatment for disorders relating to delays in learning, motor skills, and communications.]*

[(53)](42) Private duty nursing.

[(54)](43) Prognathic and maxillofacial surgery.

[(55)] *Prosthetic repair or replacement—not covered unless due to normal wear and tear, if there is a change in medical condition, if growth related, or medically necessary.]*

[(56)](44) Self-inflicted injuries—not covered unless related to a mental diagnosis.

(45) **Sex therapy.**

[(57)] *Services not specifically included as benefits.*

(58) *Services rendered after termination of coverage—those services otherwise covered under the agreement, but rendered after the date coverage under the agreement terminates, including services for medical conditions arising prior to the date individual coverage under the agreement terminates.*

(59) *Stimulators (for bone growth)—not covered unless prior authorized by claims administrator and clinical eligibility is met.]*

[(60)](46) Surrogacy—pregnancy coverage is limited to plan member.

[(61)] *Temporo-Mandibular* (47) **Temporomandibular Joint Syndrome (TMJ). Services are covered to diagnose the condition.**

[(62)] *Tobacco cessation—patches and gum are not covered.*

(63) *Transplant benefits at a non-network facility. Non-network facility charges and payments for transplants are limited to the following maximum only:*

(A) *Allogenic Bone Marrow—\$143,000;*

(B) *Autologous Bone Marrow—\$121,000;*

(C) *Heart—\$128,000;*

(D) *Heart and Lung—\$133,000;*

(E) *Lung—\$151,000;*

(F) *Kidney—\$54,000;*

(G) *Kidney and Pancreas—\$97,000; and*

(H) *Liver—\$153,000.*

(64) *Transplants—travel expense—requires authorization from medical plan. Limited to ten thousand dollar (\$10,000) maximum per transplant when accessing network services. Travel expenses include travel and lodging allowance for recipient and his/her immediate family travel companion. When a participant is younger than nineteen (19) years of*

*age, travel expenses are covered for both parents. Transplant facility must be more than one hundred (100) miles from the recipient's residence. Meals are not covered.]*

*[(65)](48) Travel expenses—not covered except for transplants in a **transplant** network facility.*

*[(66) Trimming of nails, corns, or calluses—not covered except for persons being treated for diabetes, peripheral vascular disease, or blindness.*

*(67) Usual, Customary, and Reasonable (UCR)—charges exceeding UCR are not covered, as applicable to the non-network benefit.*

*(68) Vitamins and nutrients—limited to prenatal agents for pregnancy, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents through the pharmacy benefit.]*

*[(69)](49) Workers' compensation—charges for services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.*

*AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3, RSMo Supp. 2010. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions six hundred ninety-five thousand seven hundred ninety-two dollars (\$695,792) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Name:</b>	<b>22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan and HDHP Limitations</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

<b>Affected Agency or Political Subdivision</b>	<b>Estimated Cost of Compliance in the Aggregate</b>
<b>Missouri Consolidated Health Care Plan</b>	<b>\$695,792</b>

**III. WORKSHEET**

Estimated cost is the annual cost of MCHCP providing coverage for bariatric surgery for calendar year 2012.

**IV. ASSUMPTIONS**

- Thirty procedures per year;
- Projected cost of procedure is \$23,193

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.070 Coordination of Benefits.** The Missouri Consolidated Health Care Plan is amending sections (2) and (3).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the coordination of benefits (COB) in the Missouri Consolidated Health Care Plan.*

(2) Definitions. The following words and terms, when used in this rule, shall have the following meanings unless the context clearly indicates otherwise:

(A) Allowable expenses.

1. Allowable expense means the necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

2. Notwithstanding this definition, items of expense under coverage/s/, such as dental care, vision care, prescription drug, or hearing-aid programs, may be excluded from the definition of allowable expense. A plan which provides benefits only for any of these items of expense may limit its definition of allowable expenses to like items of expense.

3. When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

4. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under this definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

5. When COB is restricted in its use to specific coverage in a contract (for example, major medical or dental), the definition of allowable expense must include the corresponding expenses or services to which COB applies.

6. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of this reduction will not be considered an allowable expense. Examples of these provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

A. Only benefit reductions based upon provisions similar in purpose to those described previously and which are contained in the primary plan may be excluded from allowable expenses.

B. This provision shall not be used to refuse to pay benefits because a health maintenance organization (HMO) member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services;

(3) Order of Benefit Determination Rules.

(B) Rules. MCHCP determines its order of benefits using the first of the following rules which applies:

**1. Active/inactive employee. The benefits of the plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of the plan which covers that person as a laid off or retired employee (or as that employee's dependent);**

**[1./2. Nondependent/dependent. The benefits of the plan which covers the person as an employer or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; *except that—if the person is also a Medicare beneficiary, and as a result of the rule established***

*by the Title XVIII of the Social Security Act and implementing regulations, Medicare is—*

*A. Secondary to the plan covering the person as a dependent;*

*B. Primary to the plan covering the person as other than a dependent (for example, a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent;*

*C. Primary if the person is eligible for Medicare due to disability; and*

*D. Primary after the first thirty (30) months if the person is eligible for Medicare due to end stage renal disease;]*

**3. Medicare.**

**A. If a member is an active employee and has Medicare, MCHCP is the primary plan for the active employee and his/her dependents. Medicare is the secondary plan except for members with end stage renal disease (ESRD) as defined in subparagraph (3)(B)3.D.**

**B. If a member is a retiree and has Medicare, Medicare is the primary plan for the retiree and his/her Medicare-eligible dependents. MCHCP is the secondary plan.**

**C. If a terminated vested employee with Medicare maintains coverage through one (1) of the MCHCP plans, Medicare is the primary plan and MCHCP is secondary.**

**D. If a member or his/her dependents are eligible for Medicare solely because of ESRD, the member's MCHCP plan is primary to Medicare during the first thirty (30) months of Medicare eligibility for home peritoneal dialysis or home hemodialysis and thirty-three (33) months for in-center dialysis. After the thirty (30) or thirty-three (33) months, Medicare becomes primary, and claims are submitted first to Medicare, then to MCHCP for secondary coverage. The member is responsible for notifying MCHCP of his/her Medicare status.**

**E. If a member is on long-term disability through the Missouri State Employees' Retirement System or the Public School Retirement System and is eligible for Medicare, Medicare is the primary plan and MCHCP plan is secondary;**

**[2./4. Dependent child/parents not separated or divorced. When MCHCP and another plan cover the same child as a dependent of different persons, called parents—**

**A. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but**

**B. If both parents have the same birthday, the benefits of the plan which covered one (1) parent longer are determined before those of the plans which covered the other parent for a shorter period of time;**

**[3./5. Dependent child/separated, [or] divorced, or never married. If two (2) or more plans cover a person as a dependent child of divorced, [or] separated, or never married parents, benefits for the child are determined in this order[:—**

**A. First, the plan of the parent with custody of the child;**

**B. Then, the plan of the spouse of the parent with the custody of the child;**

**C. Then, the plan of the parent not having custody of the child; and**

**D. Finally, the plan of the spouse of the parent not having custody of the child. However, if the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the plan of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge;**

[4.]/6. Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph (3)(B)/2/4.;

[5.]/7. Dependent child/parents both parents covered by MCHCP. If both parents are covered by MCHCP and both parents cover the child as a dependent, MCHCP will not coordinate benefits with itself; [and/

**8. The plan that covers the member as a spouse is primary over the plan that covers the member as a dependent child; and**

[6.]/9. Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the plan which covered a person longer are determined before those of the plan which covered that person for the shorter term.

*AUTHORITY: sections 103.059 and 103.089, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the Code of State Regulations. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.075 Review and Appeals Procedure.** The Missouri Consolidated Health Care Plan is amending sections (1)–(5); adding section (1); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to review and appeals procedures for participation in, and coverage of services under, the Missouri Consolidated Health Care Plan.*

**(1) General Provision. The board of trustees has the right to suspend, revise, or remove eligibility and benefit requirements in the case of a disaster or emergency situation.**

**[(1)](2) Claims Submissions and Initial Benefit Determinations.**

(A) Members shall use the claims and administration procedures established by the vendor administering the particular service for which coverage, authorization, or payment is sought.

(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.

1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a decision whether a treatment, procedure, or medication is medically neces-

sary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days from the date the vendor receives the claim. The vendor may extend the time period up to an additional fifteen (15) days if, for reasons beyond the vendor's control, the decision cannot be made within the first fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor as soon as possible thereafter.

2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than thirty (30) days after the vendor receives the claim. If, because of reasons beyond the vendor's control, more time is needed to review the claim, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

3. Concurrent claims are claims related to an ongoing course of previously[-] approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously[-] approved course of treatment in sufficient time to allow the member or the member's provider to appeal and obtain a determination before the benefit is reduced or terminated.

(C) Claims incurred should be furnished to the vendor by the provider or the member as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the vendor before they are paid.

(D) If a member, or a provider, or authorized representative on behalf of a member, submits a request for coverage or a claim for services that is denied in whole or in part, the member will receive an initial denial notice within the time frames described in this rule that will include the following information:

1. The reasons for the denial;

2. Reference to the plan provision, regulation, statute, clinical criteria, or guideline on which the denial was based, with information as to how the member can obtain a copy of the provision, regulation, statute, clinical criteria, or guideline free of charge;

3. A description of any documentation or information that is necessary for the member to provide if documentation or information is missing and an explanation as to why the documentation or information is needed, if applicable; and

4. Information as to steps the member can take to submit an appeal of the denial.

**//(2)/(3) General Appeal Provisions.**

(A) All individuals seeking review or appeal of a decision of the plan, plan administrator, claims administrator, or any vendor shall follow the procedures applicable to the type of decision appealed as set forth in this rule.

(B) All appeals must be submitted in writing to the appropriate reviewer as established in this rule by the member, the individual seeking review, or his/her authorized representative.

(C) Unless specifically provided otherwise in this rule, all appeals to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of receiving the denial or notice which gave *[rights]* rise to the appeal.

**//(3)/(4) Appeal Process for Medical and Pharmacy Determinations.**

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply.

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage *[once]* after an individual has been covered under the plan.

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination.

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative.

4. External review. External review means a review of an adverse benefit determination (including a final internal adverse benefit determination) by the Missouri Department of Insurance, Financial Institutions and Professional Registration, Division of Consumer Affairs (DIFP) regarding covered medical *[and pharmacy]* benefits administered by *[plan vendors, UMR, Mercy Health Plans, or Express Scripts Inc.,]* **Coventry Health Care** in accordance with state law and regulations promulgated by DIFP *[and made applicable to the plan by agreement and between the plan and DIFP pursuant to Technical Guidance from the U.S. Department of Health and Human Services dated September 23, 2010]. The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by UMR and Express Scripts Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time).*

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims

administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law.

6. Final external review decision. A final external review decision means a determination rendered under the *[DIFP]* external review process at the conclusion of an external review.

7. Rescission. A rescission means a termination or discontinuance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect;

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

C. The termination or discontinuance of coverage is effective retroactively at the request of the member in accordance with applicable provisions of this chapter regarding voluntary cancellation of coverage.

**(B) Internal Appeals.**

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review *[by DIFP]* except as specifically provided in **22 CSR 10-2.075(4)(A)4.**

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.



(II) First level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First level appeals must be submitted in writing to—

UMR Claims Appeal Unit  
PO Box 30546  
Salt Lake City, UT 84130-0546

(b) Second level appeals must be sent in writing to—

UMR Claims Appeal Unit  
PO Box 8086  
Wausau, WI 54402-8086

(c) Expedited appeals must be communicated by calling UMR telephone 1-866-868-7758 or by submitting a written fax to 1-866-912-8464, Attention: Appeals Unit.

(VI) For members with medical coverage through *[Mercy Health Plans]* **Coventry Health Care—**

(a) First and second level appeals must be submitted in writing to—

*[Mercy Health Plans]*  
*Attn: Corporate Appeals*  
14528 S. Outer 40 Road, Suite 300  
Chesterfield, MO 63017]  
**Coventry Health Care**  
**Attn: Appeals Department**  
550 Maryville Centre, Ste. 300  
St. Louis, MO 63141

(b) Expedited appeals must be communicated by calling *[Mercy Health Plans]* **Coventry Health Care** telephone *[1-800-830-1918, ext. 2394]* **1-314-214-2394** or by submitting a written fax to 1-314-214-3233, Attention: Corporate Appeals.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if

applicable) name, the date the member claimant attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the claimant believes the claim should be paid, and any other written documentation to support the claimant's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts  
*[Clinical Appeals—MH3]*  
6625 West 78th Street, BL0390]  
**Attn: Pharmacy Appeals—MH3**  
**Mail Route 0390**  
**6625 W. 78th St.**  
Bloomington, MN 55439  
or by fax to 1-877-852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

Office of Consumer Information and Oversight  
Department of Health and Human Services  
PO Box 791  
Washington DC 20044  
or by fax to 1-202-606-0036  
or by email to [disputedclaim@opm.gov](mailto:disputedclaim@opm.gov)

(III) The claimant may call the toll-free number 1-877-549-8152 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the time-frame for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

*[(4)](5)* Except as otherwise expressly provided in this rule, appeals of adverse determinations made by MCHCP may be appealed to the board by fax or letter to the following address:

Attn: Appeal  
Board of Trustees  
Missouri Consolidated Health Care Plan  
PO Box 104355  
Jefferson City, MO 65110

[(5)](6) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines.

(A) Newborns—If a member currently has coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within three (3) months of the child's date of birth.

(B) Agency error—MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office, *[the]* MCHCP, or plan offered by MCHCP that was no fault of the member.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year. **Plan changes are effective February 1. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

(D) Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).

(E) Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.

(F) Termination dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January. **If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, termination may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

(G) Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for the public entity (county or state) to provide subscriber with requested documentation.

(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage. **If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

(I) Loss of coverage notice—MCHCP may approve late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

(J) *[Wellness Program]* **Lifestyle Ladder** participation—MCHCP may deny all appeals regarding continuation of participation in the *[Wellness/]* **Lifestyle Ladder** Program due to failure of member's participation.

(K) Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.

(L) Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.

(M) New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. **If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State**

#### Employees' Cafeteria Plan.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

#### Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership

#### PROPOSED AMENDMENT

**22 CSR 10-2.090 Pharmacy Benefit Summary.** The Missouri Consolidated Health Care Plan is deleting sections (2), (4), and (8); amending the purpose, sections (1), (5), and (7); adding sections (6)–(8); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the PPO 300 Plan, PPO 600 Plan, HDHP with HSA, and Medicare Supplement Plans of the Missouri Consolidated Health Care Plan.*

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions, covered charges, limitations, and exclusions of the pharmacy benefit for the PPO 300, PPO 600, HDHP with HSA, and Medicare Supplement Plans of the Missouri Consolidated Health Care Plan.*

(1) The pharmacy benefit provides coverage for prescription drugs. *[listed on the formulary, as described in the following:]* **Vitamins and nutrients coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a physician.**

(A) *[Medications.]* **PPO 300, PPO 600, and Medicare Supplement Plan Prescription Drug Coverage.**

1. Retail—Network:

A. Generic: Eight-dollar (\$8) copayment for up to a thirty (30)-day supply for a generic drug on the formulary; **formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%);**

B. Brand: Thirty-five-dollar (\$35) copayment for up to a thirty (30)-day supply for a brand drug on the formulary; **formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%);**

C. Non-formulary: One hundred dollar (\$100) copayment for up to a thirty (30)-day supply for a drug not on the formulary;

**[C./D. [Mail order] Home delivery program—**

(I) *[Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for a twenty-dollar (\$20) copayment for a generic drug on the formulary or a eighty-seven-dollar-and-fifty-cent (\$87.50) copayment for a brand drug on the formulary.]* Maintenance prescriptions may be filled through the home delivery program. Some medications may not qualify for the program because they require prior authorization or quantity level limits.

(a) Generic: Twenty dollar (\$20) copayment for up to a ninety (90)-day supply for a generic drug on the formulary.

(b) Brand: Eighty-seven dollars and fifty cent (\$87.50) copayment for up to a ninety (90)-day supply for a brand drug on the formulary.

(c) Non-formulary: Two hundred fifty dollar (\$250) copayment for up to a ninety (90)-day supply for a drug not on the formulary; and

(II) Specialty drugs covered only through network *[mail order]* home delivery for up to thirty (30) days. *[Copayments—]* The first specialty prescription order may be filled through a retail pharmacy.

(a) Generic: *[e/]*Eight dollars (\$8) for generic drug on the formulary list*[/ and]*.

(b) Brand: *[t/]*Thirty-five dollars (\$35) for brand drug on the formulary.

(c) Non-formulary: One hundred dollar (\$100) copayment for a drug not on the formulary;

E. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

F. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment;

G. If the physician allows for generic substitution and the member chooses a brand name drug, the member is responsible for the generic copayment and the cost difference between the brand name and generic drug; and

H. Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary.

2. *[Non-network pharmacies]* Retail—Non-network:*[-]* If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. *[S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable copayment or coinsurance. All such claims must be filed within twelve (12) months of the incurred expense.]* The pharmacy plan administrator will reimburse the cost of the drug based on the network discounted amount, less the applicable copayment.

A. Generic: Eight dollar (\$8) copayment for up to a thirty (30)-day supply for a generic drug on the formulary.

B. Brand: Thirty-five dollar (\$35) copayment for up to a thirty (30)-day supply for a brand drug on the formulary.

C. Non-formulary: One hundred dollar (\$100) copayment for up to a thirty (30)-day supply for a drug not on the formulary.

*[3. Retail prescription drugs—Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.]*

(B) High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Prescription Drug Coverage.

**1. Retail—Network:**

A. Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary; tobacco cessation

prescriptions covered at one hundred percent (100%);

B. Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary; tobacco cessation prescriptions covered at one hundred percent (100%);

C. Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary;

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the home delivery program. Some medications may not qualify for the program because they require prior authorization or quantity level limits.

(a) Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

(c) Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary;

(II) Specialty drugs covered only through network home delivery for up to thirty (30) days.

(a) Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

(c) Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary; and

E. Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary through the pharmacy benefit.

2. Retail—Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. The pharmacy plan administrator will reimburse the cost of the drug based on the network discounted amount, less the applicable deductible or coinsurance.

A. Generic: Forty percent (40%) coinsurance after deductible for up to a thirty (30)-day supply for a generic drug on the formulary.

B. Brand: Forty percent (40%) coinsurance after deductible for up to a thirty (30)-day supply for a brand drug on the formulary.

C. Non-formulary: Fifty percent (50%) coinsurance after deductible for up to a thirty (30)-day supply for a drug not on the formulary.

*[[2] If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment.]*

*[[3]](2) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first step drug, the physician may request a prior authorization from the pharmacy plan administrator. If the prior authorization is approved, the member is responsible for the applicable copayment which may be higher than the first step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.*

**(A) First Step—**

1. Uses primarily generic drugs;

2. Lowest applicable copayment is charged; and

3. First step drugs must be used before the plan will authorize

payment for second step drugs.

(B) Second Step—

1. This step applies if the member's treatment plan requires a different medication after attempting the first step medication;
2. Uses primarily brand-name drugs; and
3. Typically, a higher copayment amount is applicable.

*[(4) Prior Authorization—Certain medications are subject to prior authorization. Network pharmacies will notify the member if prior authorization is required. The member or the pharmacy must contact the pharmacy plan administrator before payment will be approved.]*

*[(5)](3) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan administrator. In order to file a claim, members must—*

*(A) Complete the claim form; [and]*

*(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions, except diabetic supplies. If attaching a receipt or label, the receipt or label shall include:*

1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;
7. Quantity; and
8. Days' supply./.; and

*(C) Members must file a claim to receive reimbursement of the cost of a prescription filled at a non-network pharmacy. Non-network pharmacy claims are allowed at the network discounted price as determined by the vendor minus any applicable copayment. Members are responsible for any charge over the network discounted price and the applicable copayment.*

*[(6)](4) Formulary—The formulary is updated on a semi-annual basis, or when—*

- (A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; or*
- (B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; or*
- (C) A drug is determined to have a safety issue.*

*[(7)](5) [Limitation—Prescription drugs not listed on the formulary are not a covered benefit except for prescription drugs that have been grandfathered for members who have taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011. If the participant purchased a brand-name drug that is grandfathered when there is a Food and Drug Administration (FDA)-approved generic drug, the participant shall pay the generic copayment plus the difference in the brand and generic cost of the drug.] Grandfathered Specialty Drugs—Prescription drugs grandfathered for members in 2011 because they had taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011, will continue to be covered at a thirty-five dollar (\$35) brand copayment level if enrolled in a PPO plan or at twenty percent (20%) coinsurance if enrolled in the HDHP plan. Grandfathered drugs include:*

- (A) Alzheimer's disease drugs;*
- (B) Antidepressants, including selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and norepinephrine reuptake inhibitors (SNRIs);*
- (C) Anti-epileptics;*
- (D) Attention-deficit hyperactivity disorder (ADHD);*

*[(D)](E) Biologics for inflammatory conditions;*

*[(E)](F) Cancer drugs;*

*[(F)](G) Hemophilia drugs (/F/factor VIII and IX concentrates);*

*[(G)](H) Hepatitis drugs;*

*[(H)](I) Immunosuppressants (transplant anti-rejection agents);*

*[(I)](J) Insulin (basal);*

*[(J)](K) Low molecular weight heparins;*

*[(K)](L) Multiple sclerosis injectable drugs;*

*[(L)](M) Novel psychotropics (oral products and long-active injectables);*

*[(M)](N) Phosphate binders;*

*[(N)](O) Pulmonary hypertension drugs; and*

*[(O)](P) Somatostatin analogs.*

*[(8) Under the High Deductible Health Plan (HDHP), pharmacy benefits are subject to the applicable medical plan deductible and coinsurance.]*

**(6) Medicare Part B Prescription Drugs—For covered Medicare Part B prescriptions, Medicare and MCHCP will coordinate to provide up to one hundred percent (100%) coverage for the drugs. To receive Medicare Part B prescriptions without a copayment or coinsurance, the subscriber must submit prescriptions and refills to an MCHCP vendor-contracted participating Medicare Part B retail pharmacy or use the MCHCP vendor-contracted home delivery service. Medicare Part B prescriptions include, but are not limited to, the following:**

**(A) Diabetes testing and maintenance supplies;**

**(B) Respiratory agents;**

**(C) Immunosuppressants; and**

**(D) Oral anti-cancer medications.**

**(7) Quantity Level Limits—Quantities of some medications may be limited based on recommendations by the Food and Drug Administration and medical literature. Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.**

**(8) Guidelines for Drug Use—If MCHCP suspects drug misuse, abuse, or fraud, MCHCP reserves the right to pay only for those medications prescribed by an assigned physician approved by MCHCP.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2005, effective Jan. 1, 2006, expired June 29, 2006. Original rule filed Dec. 22, 2005, effective Jan. 30, 2006. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions \$71,108,598 in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities \$22,866,726 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Name:</b>	<b>22 CSR 10-2.090 Pharmacy Benefit Summary</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan</b>	<b>\$ 71,108,598</b>

**III. WORKSHEET**

Estimated cost is the annual MCHCP pharmacy contribution toward premiums for providing pharmacy benefits to state employees, retirees and dependents who enroll for coverage under an MCHCP plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under MCHCP Plans as of August 1, 2011 (data used the CY2012 projection);
- Calendar year 2012 membership in all MCHCP Plans remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Actual claim costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.090 Pharmacy Benefit Summary</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>97,994 individuals enrolled in the MCHCP Plans for CY 2012</b>	<b>Individuals enrolled in the MCHCP Plans for CY 2012</b>	<b>\$ 22,866,726</b>

**III. WORKSHEET**

Estimated cost is the annual MCHCP subscribers' premiums for pharmacy coverage for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment in the MCHCP pharmacy plan as of August 1, 2011 (data used for the CY2012 projection);
- Calendar year 2012 membership in the MCHCP pharmacy plan remains relatively stable;
- Calendar year 2012 rates based on projections of self-insured premiums as developed by MCHCP's actuary;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-2.091 Wellness Program Coverage, Provisions, and Limitations.** The Missouri Consolidated Health Care Plan is amending sections (1)–(4).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the wellness program.*

(1) Eligibility—*[All non-Medicare primary active, retiree, terminated vested, long term disability (LTD), survivor, and Consolidated Omnibus Budget Reconciliation Act (COBRA) subscribers and their non-Medicare primary spouses enrolled in a Missouri Consolidated Health Care Plan (MCHCP) medical plan may participate in the wellness program.] All Missouri Consolidated Health Care Plan (MCHCP) subscribers and covered spouses who do not have the TRICARE Supplement Plan or Medicare as primary coverage are eligible.* Each eligible member must participate separately.

(A) *[Members]* **Eligible members** may begin participating on or after their eligibility date or during the open enrollment (OE) period.

(2) Limitations and Exclusions.

**(C) Dependent children who are covered under a parent's plan and who are also state employees are not eligible to participate.**

*[(C)](D)* Members must have a Social Security number on file with MCHCP to be eligible to participate.

*[(D)](E)* When Medicare becomes a subscriber's primary insurance payer, the subscriber and participating spouse are no longer eligible to participate and will lose the wellness premium.

*[(E)](F)* When Medicare becomes a spouse's primary insurance payer, the spouse is no longer eligible to participate and will lose the wellness premium. The non-Medicare subscriber may continue to participate in the program.

(3) Participation. Members earn points through successful completion of activities as specified in the wellness program web portal through myMCHCP.

(A) The wellness program is *[voluntary]* **called Lifestyle Ladder.**

**(B) The Lifestyle Ladder program is voluntary.**

*[(B)](C)* Members are responsible for enrolling, participating, and completing activities, as well as keeping track of their applicable deadlines and points.

*[(C)](D)* Each activity has different enrollment, participation, and completion criteria.

1. Some activities require use of the Internet and/or a unique email address.

2. The vendor will make all determinations regarding activity enrollment, participation, and completion.

3. The vendor will award all points upon completion of an activity.

4. Completion of activities outside of the wellness participation period may result in points being applied to the next wellness participation period.

5. Members with disabilities may request special accommodations in writing to the vendor regarding activity participation.

*[(D)](E)* The required HA must be completed annually before points begin accruing.

*[(E)](F)* Points are assigned by the vendor in the wellness participation period in which they are earned by the participating member.

*[(F)](G)* The wellness participation period is the time frame in which activities must be completed in order to earn the wellness pre-

mium. The wellness participation periods are as follows: *[October 1–December 25; January 1–March 25; April 1–June 25; and July 1–September 25]* **October 1–November 25; December 1–February 25; March 1–May 25; and June 1–August 25.**

*[(G)](H)* The wellness coverage period is the time frame in which members receive the wellness premium for participation. The wellness coverage periods are as follows: January 1–March 31; April 1–June 30; July 1–September 30; and October 1–December 31.

*[(H)](I)* MCHCP and/or the vendor may audit participation information for accuracy. Misrepresentation or fraud could lead to termination from the wellness program, loss of the wellness premium, and/or prosecution.

(4) Wellness Premium. Members qualify for the wellness premium as follows:

(B) Points are accumulated in and can be monitored by the participating member from the wellness program web portal accessed through myMCHCP **or by calling the vendor; and**

(C) Members reaching the minimum one hundred (100)-point threshold per wellness participation period will receive the wellness premium **(fifteen dollars (\$15) off his or her monthly premium)** in the future wellness coverage period.

1. Members earning over one hundred (100) points in a given wellness participation period will receive the wellness premium in the future wellness coverage period, and all points over one hundred (100) will roll forward to be applied toward meeting the one hundred (100)-point threshold during the next wellness participation period.

2. Members not earning at least one hundred (100) points in a given wellness participation period will not receive the wellness premium for the future wellness coverage period, but the points earned totaling less than one hundred (100) will roll forward to be applied toward meeting the one hundred (100)-point threshold during the next wellness participation period.

3. A maximum of four hundred (400) points per wellness participation year is possible.

4. All earned points zero out at the end of the wellness participation year; *and*.

*[(D)]* **The wellness premium will be applied to subscriber paychecks or retiree benefit checks at the beginning of each wellness coverage period.]**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 20, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Nov. 25, 2011, expires May 22, 2012. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED RESCISSION**

**22 CSR 10-2.092 Dental Benefit Summary.** This rule established the policy of the board of trustees in regard to the dental benefit summary for members of the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded and readopted to clarify the dental benefit is governed by a fully-insured plan.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Rescinded: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED RULE**

**22 CSR 10-2.092 Dental Coverage**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to dental coverage for members of the Missouri Consolidated Health Care Plan.*

(1) The plan administrator may offer dental coverage through a vendor.

(A) Dental plan design is defined by the vendor.

(B) Dental plan eligibility, enrollment, and termination requirements are determined by the plan administrator and are defined in 22 CSR 10-2.020.

(C) Total dental premium costs for all coverage levels are fully paid by the member and collected by the plan administrator.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Rescinded and readopted: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rule will cost private entities \$15,946,510 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*



**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 – Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.092 Dental Benefit Summary</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>65,549 individuals enrolled in MCHCP Dental Plan for CY 2012</b>	<b>Individuals enrolled in the MCHCP Dental Plan for CY 2012</b>	<b>\$15,946,510</b>

**III. WORKSHEET**

Estimated cost is the annual MCHCP subscribers' premiums for dental coverage for calendar year 2012. Dental coverage is limited to a \$1,000 per person calendar year benefit.

**IV. ASSUMPTIONS**

- Total enrollment in the MCHCP dental plan as of August 1, 2011 (data used for the CY2012 projection);
- Calendar year 2012 membership in the MCHCP dental plan remains relatively stable;
- Calendar year 2012 rates based on projections of fully-insured premiums as developed by Delta Dental;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED RESCISSION**

**22 CSR 10-2.093 Vision Benefit Summary.** This rule established the policy of the board of trustees in regard to the vision benefit summary for members of the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded and readopted to clarify the vision benefit is governed by a fully-insured plan.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Rescinded: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED RULE**

**22 CSR 10-2.093 Vision Coverage**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to vision coverage for members of the Missouri Consolidated Health Care Plan.*

(1) The plan administrator may offer vision coverage through a vendor.

(A) Vision plan design is defined by the vendor.

(B) Vision plan eligibility, enrollment, and termination requirements are determined by the plan administrator and are defined in 22 CSR 10-2.020.

(C) Total vision premium costs for all coverage levels are fully paid by the member and collected by the plan administrator.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Rescinded and readopted: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rule will cost private entities \$2,580,562 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 – Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.093 Vision Benefit Summary</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>57,196 individuals enrolled in MCHCP Vision Plan for CY 2012</b>	<b>Individuals enrolled in the MCHCP Vision Plan for CY 2012</b>	<b>\$2,580,562</b>

**III. WORKSHEET**

Estimated cost is the annual MCHCP subscribers' premiums for the vision plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment in the MCHCP vision plan as of August 1, 2011 (data used for the CY2012 projection);
- Calendar year 2012 membership in the MCHCP vision plan remains relatively stable;
- Calendar year 2012 rates based on projections of fully-insured premiums as developed by Vision Service Plan;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED RULE**

**22 CSR 10-2.094 Tobacco-Free Incentive Provisions and Limitations**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the tobacco-free incentive benefit.*

(1) Eligibility—All Missouri Consolidated Health Care Plan (MCHCP) subscribers and covered spouses who do not have the TRICARE Supplement Plan or Medicare as primary coverage are eligible. A spouse of a Medicare primary employee who is a retiree, long-term disability (LTD), or survivor may not participate in the tobacco-free incentive regardless of the spouse's Medicare eligibility status. Each eligible member must participate separately.

(A) Eligible members must attest when they become eligible for coverage or during the open enrollment period to receive the incentive.

(B) Eligible members with a break in coverage within the same plan year must complete the tobacco-free attestation by fax or mail.

(2) Limitations and Exclusions.

(A) Dependent children are not eligible to receive the incentive.

(B) Dependent children who are covered under a parent's plan and who are also state employees are not eligible to receive the incentive.

(C) When Medicare becomes a subscriber's primary insurance payer, the subscriber and participating spouse are no longer eligible to receive the incentive.

(D) When Medicare becomes a spouse's primary insurance payer, the spouse is no longer eligible to receive the incentive. The non-Medicare subscriber may continue to receive the incentive.

(3) Incentive Participation Requirement.

(A) To receive the incentive beginning on January 1, 2012, eligible members must do one (1) of the following:

1. Tobacco-free attestation.

A. The member must complete a tobacco-free attestation online through myMCHCP or submit a completed form by fax or mail during the period of October 1, 2011, through November 25, 2011. The form must be received by November 25, 2011; or

2. Tobacco cessation program attestation.

A. Participate in an MCHCP approved tobacco cessation program as defined in section (3) and complete a tobacco cessation program attestation online through myMCHCP or submit a completed form by fax or mail during the period of October 1, 2011, through November 25, 2011. The form must be received by November 25, 2011.

(I) If a subscriber and his/her spouse become and remain tobacco-free three (3) months prior to May 25, 2012, s/he may continue to receive the incentive through December 31, 2012, if s/he completes a tobacco-free attestation through myMCHCP or submit a completed form by fax or mail by May 25, 2012. The form must be received by May 25, 2012.

(B) For a new employee or an employee added during a special enrollment period and his/her spouse to receive the incentive from the employee's effective date of coverage, the employee must complete a tobacco-free attestation or tobacco cessation program attestation at the time of enrollment. A covered spouse's attestation must be completed within thirty-one (31) days of enrollment. If a subscriber and/or his/her spouse complete the tobacco cessation program attestation and become and remain tobacco-free three (3) months prior to May 25, 2012, s/he can continue to receive the incentive through December 31, 2012, if s/he completes a tobacco-free attestation

through myMCHCP or submits a completed form by fax or mail by May 25, 2012. A form must be received by May 25, 2012. A new employee and spouse added during a special enrollment period after May 25, 2012, must complete the tobacco-free attestation form to receive the incentive within thirty-one (31) days of enrollment.

(C) A waiver may be granted if a member provides a physician certification that a medical condition prevents the member from achieving tobacco-free status.

(D) Eligible members with a break in coverage within the same plan year must again attest to be tobacco-free through an online attestation or submit a paper attestation form to MCHCP.

(E) If a member attests to be tobacco-free but starts to use tobacco products, he/she must contact MCHCP through myMCHCP or by phone, fax, or mail immediately to change his/her status. MCHCP will adjust his/her premium for coverage beginning the second month after the member self reports.

(F) MCHCP may audit the attestation for accuracy.

(4) MCHCP approved tobacco cessation programs are—

(A) StayWell Tobacco NextSteps: Phone coaching (866-564-5235);

(B) Missouri Tobacco Quitline: 800-QUIT-NOW (800-784-8669); or

(C) American Cancer Society Quit for Life (866-784-8454).

(5) MCHCP may utilize participation data for purposes of offering additional programs in accordance with the MCHCP privacy policy.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Nov. 1, 2011, effective Nov. 25, 2011, expires May 22, 2012. Original rule filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rule will cost private entities \$1,618,770 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.094 Tobacco-Free Incentive Provisions and Limitations</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>5,396 individuals do not attest to being tobacco-free or participating in tobacco cessation program for CY 2012</b>	<b>Individuals that do not attest to being tobacco-free or participating in a tobacco cessation program in CY 2012</b>	<b>\$1,618,770</b>

**III. WORKSHEET**

Estimated cost is the annual additional premium cost to MCHCP eligible subscribers and spouses that do not attest to being tobacco-free or participating in a tobacco cessation program for calendar year 2012.

**IV. ASSUMPTIONS**

- Projected 10 percent of eligible subscribers and spouses do not attest to being tobacco-free or participating in a tobacco cessation program

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED RULE**

**22 CSR 10-2.095 TRICARE Supplement Plan**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the TRICARE Supplement Plan benefit provisions and covered charges for members of the Missouri Consolidated Health Care Plan.*

(1) TRICARE is the Department of Defense's health insurance program for the military community. Primary coverage is through TRICARE with the Missouri Consolidated Health Care Plan TRICARE Supplement Plan paying secondary on claims.

(A) TRICARE Supplement Plan design is defined and provided by the Association and Society Insurance Corporation (ASI).

(B) TRICARE Supplement Plan eligibility, enrollment, and termination requirements are determined by ASI.

(C) Total TRICARE Supplement Plan premium costs for all coverage levels are fully paid by the member and collected by the plan administrator.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Original rule filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rule will cost private entities seven thousand one hundred seventy-five dollars (\$7,175) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 2**

<b>Rule Number and Title:</b>	<b>22 CSR 10-2.095 TRICARE Supplement Plan</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>150 individuals enrolled in the MCHCP TRICARE Supplement Plan for CY 2012</b>	<b>Individuals enrolled in the MCHCP TRICARE Supplement Plan for CY 2012</b>	<b>\$7,175</b>

**III. WORKSHEET**

Estimated cost is the annual MCHCP subscribers' premiums for coverage under the TRICARE Supplement Plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Projected enrollment in the TRICARE Supplement Plan as of January 1, 2012;
- Projected calendar year 2012 membership in the TRICARE Supplement Plan remains relatively stable;
- Calendar year 2012 rates based on fully-insured premiums as determined by ASI.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**PROPOSED RULE**

**22 CSR 10-2.100 Fully-Insured Medical Plan Provisions**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the fully-insured plan provisions of the Missouri Consolidated Health Care Plan.*

(1) A fully-insured medical plan is subject to applicable Department of Insurance, Financial Institutions and Professional Registration (DIFP) statutes and regulations. Members enrolled in a fully-insured medical plan will have rights and responsibilities as provided in those applicable statutes and regulations. If and to the extent there is a conflict between the plan and DIFP statutes and regulations, DIFP statutes and regulations shall prevail. Governing DIFP statutes and regulations include but are not limited to appeals, timelines, and payments.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Original rule filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-3.010 Definitions.** The Missouri Consolidated Health Care Plan is deleting sections (6), (8), (9), (11), (13), (16), (19), (21), (22), (24)–(26), (29)–(32), (34), (36), (39), (42), (47), (50)–(53), (55)–(58), (61), (62), (64)–(66), (70), (77)–(80), (82)–(85), (87)–(89), (92), (95), (98)–(103), (105), (109)–(111), (113), (114), (122)–(124), (126), (127), (129), and (131); amending sections (1), (3)–(5), (10), (14), (18), (23), (28), (33), (37), (38), (41), (43), (46), (48), (53), (69), (72), (74), (76), (81), (86), (93), (96), (97), (104), (112), (117), and (128); adding sections (7), (20), (22), (28), (43), and (54); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the definitions of the Missouri Consolidated Health Care Plan relative to public entities and public entity members.*

(1) Accident. An unforeseen and unavoidable event resulting in an injury [which is not due to any fault or misconduct on the part of the person injured].

(3) Administrative appeal. A written request submitted by or on behalf of a member involving plan-related administrative issues such as eligibility, effective dates of coverage, and plan changes[, etc].

(4) Adverse benefit determination. [When the claims administrator reviews an admission, availability of care, continued stay, or other health care service and decides that it is not medically necessary, appropriate, or effective. Therefore, payment for the requested service is denied, reduced, or terminated.] An adverse benefit determination means any of the following:

(A) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit based on a determination of an individual's eligibility to participate in the plan;

(B) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, investigational, or not medically necessary or appropriate; or

(C) Rescission of coverage after an individual has been covered under the plan.

(5) Allowable [expense] amount. [Charges for services rendered or supplies furnished by a health plan that would qualify as covered expenses and for which the program pays in whole or in part, subject to any deductible and coinsurance amounts.] Maximum amount on which payment is based for covered health care services. This may be called eligible expense, payment allowance, or negotiated rate. If the provider charges more than the allowed amount, the member may be balance-billed. See balance billing, section (7).

[(6) Appeal. A written complaint submitted by or on behalf of a member regarding one (1) of the following:

(A) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; or

(B) Claim payment, handling, or reimbursement for pharmacy benefits or health care services.]

(7) [(6)] Applied behavior analysis. The design, implementation, and evaluation of environmental modifications, using behavior stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior.

[(8) Assignment. When a doctor agrees to accept Medicare's fee as full payment.

(9) Benefit period. The three hundred sixty-five (365) days immediately after the first date of the services to treat a given condition.]

(7) Balance billing. When a provider bills for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is one hundred dollars (\$100) and the allowed amount is seventy dollars (\$70), the provider may bill the member for the remaining thirty dollars (\$30). A network provider may not balance bill.

[(10)](8) Benefits. [Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator.] Health care services covered by the plan.



*[(11)]* **Birthday rule.** *If both parents have medical coverage, the primary plan for dependent children is the plan of the parent whose birthday occurs first in the calendar year. If birthdays occur on the same day, the parent's coverage that has been in effect longest is primary.*

*[(12)]***(9)** **Board.** The board of trustees of the Missouri Consolidated Health Care Plan (MCHCP).

*[(13)]* **Calendar year.** *The period of time from January 1 through December 31. This is the period during which the total amount of annual benefits is calculated. All annual deductibles and benefit maximums accumulate during the calendar year.*

*[(14)]***(10)** **Cancellation of coverage.** The *[voluntary cancellation]* **ending** of medical, dental, or vision coverage per a subscriber's **voluntary** request.

*[(15)]***(11)** **Case management.** A coordinated set of activities conducted for individual patient management of serious or complicated health conditions.

*[(16)]* **Chiropractic services.** *The examination, diagnosis, adjustment, manipulation, and treatment of malpositioned articulations and structures of the body, directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health.*

*[(17)]***(12)** **Claims administrator.** An organization or group responsible for the processing of claims and associated services for a health plan.

*[(18)]***(13)** **Coinsurance.** *[The shared portion of payment between the plan and the subscriber where each pays a percentage of covered charges.]* **The member's share of the costs of a covered health care service, calculated as a percent (for example, twenty percent (20%)) of the allowed amount for the service. The member pays coinsurance plus any deductibles owed. For example, if the health insurance or plan's allowed amount for an office visit is one hundred dollars (\$100) and the member has met his/her deductible, the member's coinsurance payment of twenty percent (20%) would be twenty dollars (\$20). The health insurance or plan pays the rest of the allowed amount.**

*[(19)]* **Comprehensive major medical.** *A plan that provides for cost sharing to be applied to all covered expenses, such as deductible or coinsurance.*

*[(20)]***(14)** **Congenital defect.** Existing or dating from birth. Acquired through development while in the uterus.

*[(21)]* **Convenient care clinics (CCCs).** *Health care clinics located in retail stores, supermarkets, and pharmacies that treat routine family illnesses and provide preventive health care services. They are sometimes referred to as "retail-based clinics" or "walk-in medical clinics."*

*(22)* **Coordination of benefits.** *Communication, adjustment, and reconciliation procedures between multiple benefit plans covering the same member for purposes of covering services and expenses relating to plan benefits.*

*[(23)]***(15)** **Copayment.** *[A set dollar amount that the covered individual must pay for specific services.]* **A fixed amount for example, fifteen dollars (\$15) the member pays for a covered health care service, usually when the member receives the ser-**

**vice. The amount can vary by the type of covered health care service.**

*[(24)]* **Cosmetic surgery.** *A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than restore the anatomy and/or function of the body which are lost or impaired due to illness or injury.*

*(25)* **Covered benefits and charges.** *Covered benefits are a schedule of health care services payable under the plan. Covered charges are the cost for medical services eligible for consideration under the plan.*

*(26)* **Custodial care.** *Services and supplies furnished primarily to assist an individual to meet the activities of daily living that can be provided by persons without the training of a health care provider or that do not entail and require the continuing attention of trained medical or paramedical personnel.*

*[(27)]***(16)** **Date of service.** Date medical services are received.

*[(28)]***(17)** **Deductible.** *[The amount of expense the member must pay before the plan begins to pay for covered services and supplies. This amount is not reimbursable by the plan.]* **The amount the member owes for health care services that the health plan covers before the member's health plan begins to pay. For example, if the deductible is one thousand dollars (\$1,000), the member's plan will not pay anything until s/he meets his/her one thousand dollars (\$1,000) deductible for covered health care services subject to the deductible. The deductible may not apply to all services.**

*[(29)]* **Dependent child.** *Any child under the age of twenty-six (26) that is a natural child, legally adopted or placed for adoption child, or a child with one (1) of the following legal relationships with the member, so long as such legal relationship remains in effect:*

*(A) Stepchild;*

*(B) Foster child;*

*(C) Grandchild for whom the employee has legal guardianship or legal custody; and*

*(D) Other child for whom the employee is court-ordered legal guardian.*

*1. Except for a disabled child as described in 22 CSR 10-3.010(88), a dependent child is eligible from his/her eligibility date to the end of the month he/she attains age twenty-six (26).*

*2. A child who is a dependent child under a guardianship of a minor will continue to be a dependent child when the guardianship ends by operation of law when the child becomes eighteen (18) years of age if such child was an MCHCP member the day before the child becomes eighteen (18) years of age.*

*(30)* **Dependents.** *The lawful spouse of the employee, the employee's unemancipated child(ren), and certain survivors of employees, as provided in the plan document and these rules, for whom application has been made and has been accepted for participation in the plan.*

*(31)* **Diagnostic.** *Describes a procedure to determine whether a person has a particular illness.*

*(32)* **Diagnostic charges.** *The Usual, Customary, and Reasonable (UCR) charges or the network discounted rate (NDR) for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.]*

**[(33)](18)** Disease management. A program offered to *[non-Medicare]* members, who do not have primary Medicare coverage, to help manage certain chronic diseases.

**[(34)]** Disposable supplies. *Supplies that do not withstand prolonged use and are periodically replaced. Includes, but not limited to, colostomy and ureterostomy bags.*

**[(35)](19)** Doctor/physician. A licensed practitioner of the healing arts, as approved by the plan administrator, including:

- (A) Doctor of medicine;
- (B) Doctor of osteopathy;
- (C) Podiatrist;
- (D) Optometrist;
- (E) Chiropractor;
- (F) Psychiatrist;
- (G) Psychologist;
- (H) Doctor of dental medicine, including dental surgery;
- (I) Doctor of dentistry; or
- (J) Qualified practitioner of spiritual healing whose organization is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized.

**[(36)]** Durable medical equipment (DME). *Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Such equipment is not covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.*

**(20)** Effective date. The date on which coverage takes effect as described in 22 CSR 10-3.020(4).

**[(37)](21)** Eligibility date. The first day a member is qualified to enroll for coverage *[A]* as described in 22 CSR 10-3.020(2).

**(22)** Eligibility period. The time allowed to enroll in accordance with the rules in this chapter.

**[(38)](23)** Emergency medical condition. *[A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—*

- (A) Conditions placing a person's health in significant jeopardy;*
- (B) Serious impairment to a bodily function;*
- (C) Serious dysfunction of any bodily organ or part;*
- (D) Inadequately controlled pain; or*
- (E) Situations when the health of a pregnant woman or her unborn child are threatened.] The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:*

- (A) Placing a person's health in significant jeopardy;*
- (B) Serious impairment to a bodily function;*
- (C) Serious dysfunction of any bodily organ or part;*
- (D) Inadequately controlled pain; or*
- (E) With respect to a pregnant woman who is having contractions—*

*1. That there is inadequate time to effect a safe transfer to another hospital before delivery; or*

*2. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.*

**[(39)]** Emergency room. *The section of a hospital equipped to furnish emergency care to prevent the death or serious impairment of the covered person.]*

**[(40)](24)** Emergency Services. With respect to an emergency medical condition—

(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient. The term “to stabilize” means to provide such medical treatment of the condition as may be necessary to *[assure]* ensure, within reasonable medical probability that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility.

**[(41)](25)** Employee. A benefit-eligible person employed by a participating public entity and present and future retirees from the participating public entity who meet the plan eligibility requirements *[as prescribed by the participating public entity]*.

**[(42)]** Employee and dependent participation. *Participation of an employee and the employee's eligible dependents. Any individual eligible for participation as an employee is not eligible as a dependent except as noted in 22 CSR 10-3.030(1)(A)7.]*

**[(43)](26)** Employer. The public entity that employs the eligible employee *[as defined above]*.

**[(44)](27)** Essential benefits. The plan covers essential benefits as required by the Patient Protection and Affordable Care Act. Essential benefits include:

(A) Ambulatory patient services—office visits, urgent care, outpatient diagnostic procedures, outpatient surgery, and outpatient hospice;

(B) Emergency services—ambulance services and emergency room services;

(C) Hospitalization—inpatient hospital benefits, inpatient surgery, transplants, and inpatient hospice;

(D) Maternity and newborn care—maternity coverage and newborn screenings;

(E) Mental health and substance abuse disorder services, including behavioral health treatment—inpatient and outpatient and mental health/chemical dependency office visits;

(F) Prescription drugs;

(G) Rehabilitative and habilitative services and devices—durable medical equipment; cardiac and pulmonary rehabilitation; outpatient physical, speech, and occupational therapy; and home health care/*palliative services*;

(H) Laboratory services—lab and *[x]*/X-ray;

(I) Preventive and wellness services and chronic disease management; and

(J) Pediatric services, including oral and vision care—routine vision exam, dental care/accidental injury, immunizations, preventive services, and newborn screenings.

**(28)** Excluded services. Health care services that the member's health plan does not pay for or cover.

**[(45)](29)** Executive director. The chief executive officer of the Missouri Consolidated Health Care Plan (MCHCP) who shall have charge of the offices, records, and employees of the plan, subject to the direction of the board of trustees.

[(46)](30) Experimental/Investigational/Unproven. A treatment, procedure, device, or drug that meets any of the criteria listed below **and that the plan administrator determines, in the exercise of its discretion,** is considered experimental/investigational/unproven and is not eligible for coverage under the plan[. *Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community. Experimental/investigational/unproven is defined as a treatment, procedure, device, or drug that the plan administrator determines, in the exercise of its discretion*].—

(A) Has not received the approval of the U.S. Food and Drug Administration for marketing the drug or device at the time it is furnished, if such approval is required by law;

(B) Is shown by reliable evidence to be the subject of ongoing Phase I clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficiency, or its efficacy as compared with the standard means of treatment or diagnosis; or

(C) Is shown by reliable evidence that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficiency as compared with the standard means of treatment or diagnosis.

**(D) Reliable evidence includes anything determined to be such by the plan administrator, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.**

[(47)] First eligible. *The first thirty-one (31)-day period after a member's employment date in which the member and his/her dependents may enroll in an MCHCP plan. As a member acquires new dependents, his/her first eligible period is the first thirty-one (31) days from the date of the lift event.*

[(48)](31) Formulary. A list of **U.S. Food and Drug Administration approved** drugs [covered] and supplies developed by the pharmacy benefit manager and [as allowed] covered by the plan administrator.

[(49)](32) Generic drug. A chemical equivalent of a brand-name drug with an expired patent. The color or shape may be different, but the active ingredients must be the same for both.

[(50)] Group health plan. *A plan maintained by an employer or an employee organization to provide medical care or other health services, directly or indirectly, to employees, former employees, and their families, including but not limited to Medicare and Medicaid plans.*

(51) Handbook. *The summary plan document prepared for members explaining the terms, conditions, and all material aspects of the plan and benefits offered under the plan, a copy of which is incorporated by reference into this rule. The full text of material incorporated by reference is available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, 2011 Public Entity Member Handbook (March 15, 2011) or online at [www.mchcp.org](http://www.mchcp.org). It does not include any later amendments or additions.*

(52) Health care benefit. *Coverage under the plan to include medical, dental, vision, and pharmacy.*

[(53)](33) Health savings account (HSA). A tax-advantaged savings account that may be used to pay for current or future qualified medical expenses. Enrollment in the plan's qualified High Deductible Health Plan is required for participation in an HSA. *[HSA funds can be used to help pay the deductible, coinsurance, and any qualified medical expenses not covered by the health plan.]*

[(54)](34) High Deductible Health Plan (HDHP). A health plan with a higher deductible/s/ than a traditional health plan that, when combined with an HSA, provides a tax-advantaged way to help save for future medical expenses.

[(55)] Home health care. *Skilled nursing services and other therapeutic services to persons in their homes provided by an agency certified by Medicare and licensed pursuant to state or local law.*

(56) Hospice. *A public agency, private organization, or a subdivision of either that primarily engages in providing care to terminally ill individuals, meets the conditions of participation for hospices, holds a valid Medicare provider agreement, and is licensed pursuant to state law.*

(57) Hospice facility. *A public or private organization, certified by Medicare and any other state's licensing or certifying body, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill. The facility must have an interdisciplinary medical team consisting of at least one (1) physician, one (1) registered nurse, one (1) social worker, one (1) volunteer, and a volunteer program. A hospice facility is not a facility, or part thereof, which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.*

(58) Hospital.

(A) An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic, and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24)-hour-a-day nursing service by a registered nurse (RN) on duty or call.

(B) An institution not meeting all the requirements of subsection (58)(A) above, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

(C) An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

(D) A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

(E) A residential alcoholism, chemical dependency, or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction.

(F) In no event shall the term hospital include a skilled nursing facility or any institution, or part thereof, which is used primarily as a skilled nursing facility, nursing home, rest home, or facility for the aged.]

[(59)](35) Illness. Any bodily sickness, disease, or mental/nervous disorder. For purposes of this plan, pregnancy is considered [as any other] an illness.

[(60)](36) Incident. A definite and separate occurrence of a condition.

[(61)] *Infertility. Any medical condition causing the inability or diminished ability to reproduce.*

[(62)] *Infertility services. Services including confinement, treatment, or other services related to the restoration of fertility or the promotion of conception.]*

[(63)](37) *Injury. A condition that results independently of an illness and all other causes and is a result of an external force or accident.*

[(64)] *Inpatient. Confined to a registered bed. Patient in hospital, skilled nursing facility, hospice facility, or free-standing chemical dependency treatment center.*

[(65)] *Life events. Events occurring in an individual's life to include: marriage, birth, adoption, or placement of children.*

[(66)] *Lifetime. The period of time a member or the member's eligible dependents participate in the plan.]*

[(67)](38) *Lifetime maximum. The amount payable by a medical plan during a covered member's life for specific non-essential benefits.*

[(68)](39) *MCHCPid. An individual MCHCP member identifier used for member verification and validation.*

[(69)](40) *myMCHCP. A secure MCHCP member website that [includes coverage selection, level of coverage, an option to change a mailing address, an option to add or change an email address, an option to request an MCHCPid card, and access to other pertinent websites] allows members to review coverage selections, verify covered dependents, make coverage changes, add/change email address, and access health plan websites.*

[(70)] *Medical benefits coverage. Services that are received from providers recognized by the plan and are covered benefits under the plan.]*

[(71)](41) *Medically necessary. Treatments, procedures, services, or supplies that the plan administrator determines, in the exercise of its discretion—*

(A) Are expected to be of clear clinical benefit to the patient;  
(B) Are appropriate for the care and treatment of the injury or illness in question; and

(C) Conform to standards of good medical practice as supported by applicable medical and scientific literature. A treatment, procedure, service, or supply must meet all criteria listed above to be considered medically necessary and to be eligible for coverage under the plan. In addition, the fact that a provider has prescribed, ordered, or recommended a treatment, procedure, service, or supply does not, in itself, mean that it is medically necessary as defined above. Further, the treatment, procedure, service, or supply must not be specifically excluded from coverage under this plan.

[(72)](42) *Medicare [allowed]-approved amount. The fee Medicare sets as reasonable for a covered medical service. This is the amount a provider is paid by the member and Medicare for a service or supply. It may be less than the actual amount charged by a [doctor or] health care provider.*

(43) **Medicare assignment. When a health care provider agrees to accept the Medicare-approved amount as payment in full for claims.**

[(73)](44) *Member. Any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.*

[(74)] *Network provider. A physician, hospital, pharmacy, or other health provider that is contracted with the plan or its designee.]*

(45) **Network. The facilities, providers, and suppliers the health insurer or plan has contracted with to provide health care services.**

[(75)](46) *Non-formulary. A drug not contained on the pharmacy benefit manager's list of covered drugs.*

[(76)](47) *Non-network [provider or non-participating provider. Any physician, hospital, pharmacy, or other health provider that does not have a contract with the plan or its designee]. The facilities, providers and suppliers the health plan does not contract with to provide health care services.*

[(77)] *Nurse. A registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule.*

(78) *Nursing home. An institution operated, pursuant to law, primarily for custodial care or for patients recovering from illness or injury, under the supervision of a physician or registered nurse and having twenty-four (24)-hour nursing care. Also, an institution meeting the preceding criteria which is established for the treatment of sick and injured persons through spiritual means and is operated under the authority of organizations that are recognized under Medicare.*

(79) *Open enrollment period. A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year.*

(80) *Out-of-area. Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria.]*

[(81)](48) *Out-of-pocket maximum. [The annual limit on the amount a member must pay for covered services. Above this limit, the medical plan pays one hundred percent (100%) for covered services for the rest of the plan year.] The most the member will pay during a plan year before the plan begins to pay one hundred percent (100%) of the allowed amount. This limit never includes the member's premium, copayments, balance-billed charges, or health care services the plan does not cover.*

[(82)] *Outpatient. Treatment either outside a hospital setting or at a hospital when room and board charges are not incurred.*

(83) *Outpatient observation stay. Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Most observation services are less than twenty-four (24) hours. Members may receive observation services in the emergency room, an observation unit, the intensive care unit, or a regular floor.*

(84) *Palliative services. Care provided by a team approach that improves the quality of life for patients and their families facing problems associated with life-threatening illness*

*through the prevention and relief of suffering by means of early identification and assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.*

*(85) Partial hospitalization. A distinct and organized intensive ambulatory treatment service, less than twenty-four (24)-hour daily care specifically designed for the diagnosis and active treatment of a mental/nervous disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.*

*(A) Partial hospitalization programs must provide diagnostic services; services of social workers; nurses and staff trained to work with psychiatric patients; individual, group, and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions.*

*(B) The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a physician.]*

*[(86)](49) Participant. [Any employee or dependent accepted for membership in the plan.] Shall have the same meaning as the term member defined herein. See member, section (44).*

*[(87) Pharmacy benefit manager (PBM). The PBM designs, implements, and manages the overall drug benefit of the plan and processes claims payments.*

*(88) Physically or mentally disabled. A person's inability to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition.*

*(89) Physician/Doctor. A licensed practitioner of the healing arts, acting within the scope of his/her practice, as licensed under section 334.021, RSMo.]*

*[(90)](50) Plan. The program of health care benefits established by the board of trustees of the Missouri Consolidated Health Care Plan as authorized by state law.*

*[(91)](51) Plan administrator. The board of trustees of the Missouri Consolidated Health Care Plan, which is the sole fiduciary of the plan. The board has all discretionary authority to interpret its provisions and to control the operation and administration of the plan and whose decisions are final and binding on all parties.*

*[(92) Plan document. The statement of the terms and conditions of the plan as promulgated by the plan administrator in this chapter.]*

*[(93)](52) Plan year. The [calendar year beginning] period of January 1 through December 31. [This is the period during which the total amount of annual benefits is calculated. All deductibles and benefit maximums accumulate during the calendar year.]*

*[(94)](53) Preferred provider organization (PPO). An arrangement with providers whereby discounted rates are given to plan members. Benefits are paid at a higher level when network providers are used.*

**(54) Premium. The monthly amount that must be paid for health insurance.**

*[(95) Preventive service. A procedure intended for avoidance or early detection of an illness.]*

*[(96)](55) Primary care physician (PCP). [A physician (usually a)An internist, family/general practitioner, or pediatrician/] who has contracted with a medical plan].*

*[(97)](56) Prior authorization. [A cost control procedure that requires the service or medication to be approved in advance by the doctor and/or the plan. Without prior authorization, the plan may not pay for the test, drug, or service. Also known as pre-authorization or pre-notification.] A decision by the plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called pre-authorization, prior approval, or precertification. The plan may require prior authorization for certain services before the member receives them, except in an emergency. Prior authorization is not a promise the plan will cover the cost. The provider must contact the appropriate plan administrator to request prior authorization.*

*[(98) Private duty nursing. Nursing care on a full-time basis in the member's home or home health aides.*

*(99) Proof of eligibility. Documentation required by the plan to determine a dependent's qualification for health insurance coverage.*

*(100) Proof of prior group insurance. Evidence in written form from an insurance company that provides verification of coverage for a given period of time.*

*(101) Proof of prior coverage. If a member or his/her dependents enroll in an MCHCP plan due to loss of coverage, the member must provide proof of prior group coverage. This includes a letter from the previous insurance carrier or former employer which states all the following:*

- (A) Date coverage was or will be terminated;*
- (B) Reason for coverage termination; and*
- (C) List of dependents covered.*

*(102) Prostheses. An artificial extension that replaces a missing part of the body or supplements defective parts.*

*(103) Protected health information (PHI). Any information, whether oral or recorded in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse. This information also relates to the past, present, or future physical or mental health or condition of the individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to the individual.]*

*[(104)](57) Provider. A physician, hospital, medical agency, specialist, or other duly[-]licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-3.010/(35)](19). Other providers include but are not limited to:*

- (A) Audiologist (AUD or PhD);*
- (B) Certified Addiction Counselor for Substance Abuse (CAC);*
- (C) Certified Nurse Midwife (CNM)—when acting within the scope of [their] his/her license in the state in which [they] s/he practices and performing a service which would be payable under this plan when performed by a physician;*
- (D) Certified Social Worker or Masters in Social Work (MSW);*
- (E) Chiropractor;**
- [(E)](F) Licensed Clinical Social Worker;*
- [(F)](G) Licensed Professional Counselor (LPC);*
- [(G)](H) Licensed Psychologist (LP);*

[(H)](I) Nurse Practitioner (NP);  
 [(I)](J) Physician[s] Assistant (PA);  
 [(J)](K) [Qualified] Occupational Therapist;  
 [(K)](L) [Qualified] Physical Therapist;  
 [(L)](M) [Qualified] Speech Therapist;  
 [(M)](N) Registered Nurse Anesthetist (CRNA);  
 [(N)](O) Registered Nurse Practitioner (ARNP); or  
 [(O)](P) Therapist with a PhD or Master's Degree in Psychiatry or related field.

[(105)] Provider directory. *A listing of network providers within a health plan.*

[(106)](58) Prudent layperson. An individual possessing an average knowledge of health and medicine.

[(107)](59) Public entity. A state-sponsored institution of higher learning, political subdivision, or governmental entity or instrumentality that has elected to join the plan and has been accepted by the board.

[(108)](60) Qualified Medical Child Support Order (QMCSO). A child support order from a court of competent jurisdiction or state child care agency, which requires the plan to provide coverage for a dependent child or member if the plan normally provides coverage for dependent children.

[(109)] Reconstructive surgery. *A procedure performed to restore the anatomy and/or functions of the body that are lost or impaired due to an injury or illness.*

(110) Refractions. *A record of the patient's preference for the focusing of the eyes that may then be used to purchase eyeglasses or contact lenses. It is the part of the exam that determines what prescription lens gives the patient the best possible vision.*

(111) Rehabilitation facility. *A legally operating institution, or distinct part of an institution, that has a transfer agreement with one (1) or more hospitals and is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital, and rehabilitative inpatient care, and is duly licensed by the appropriate government agency to provide such services.*

(A) *It does not include institutions that provide only minimal care, custodial care, ambulatory or part-time care services, or an institution that primarily provides treatment of mental/nervous disorders, substance abuse, or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission for the Accreditation of Rehabilitation Facilities.*

[(112)](61) Retiree. A former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-3.020/(6)/(B)/(2)(D) and is currently receiving a monthly retirement benefit from a public entity.

[(113)] Skilled nursing care. *Services that must be performed by, or under the supervision of, licensed personnel and meets criteria as established by the claims administrator.*

(114) Skilled nursing facility (SNF). *A public or private facility licensed and operated according to the law that provides—*

*(A) Permanent and full-time facilities for ten (10) or more resident patients;*

*(B) A registered nurse or physician on full-time duty in charge of patient care;*

*(C) At least one (1) registered nurse or licensed practical nurse on duty at all times;*

*(D) A daily medical record for each patient;*

*(E) Transfer arrangements with a hospital; and*

*(F) A utilization review plan.*

*The facility must be primarily engaged in providing continuous skilled nursing care for persons during the recovery stage of their illness or injury, and is not, other than by coincidence, a rest home for custodial care or for the aged.]*

[(115)](62) Sound natural teeth. Teeth and/or tissue that is viable, functional, and free of disease. A sound natural tooth has no decay, fillings on no more than two (2) surfaces, no gum disease associated with bone loss, no history of root canal therapy, is not a dental implant, and functions normally in chewing and speech.

[(116)](63) Specialty care physician/specialist. A physician who is not a primary care physician and provides medical services to members concentrated in a specific medical area of expertise.

[(117)](64) Specialty medications. High cost drugs that *[are primarily self-injectible but sometimes oral medications] treat chronic complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis.*

[(118)](65) State. Missouri.

[(119)](66) Step therapy. Designed to encourage use of therapeutically-equivalent, lower-cost alternatives before using more expensive therapy. It is especially for people who take prescription drugs regularly to treat ongoing medical conditions and is developed under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts.

[(120)](67) Subrogation. The substitution of one (1) "party" for another. Subrogation entitles the insurer to the rights and remedies that would otherwise belong to the insured (the subscriber) for a loss covered by the insurance policy. Subrogation allows the plan to stand in the place of the *[participant] member* and recover the money directly from the other insurer.

[(121)](68) Subscriber. The employee or member who elects coverage under the plan.

[(122)] Surgery. *Any operative or invasive diagnostic procedure performed in the treatment of an injury or illness by an instrument or cutting procedure through any natural body opening or incision.*

(123) Surgery center (ambulatory). *A hospital-based, hospital-sponsored, or independently-owned facility that performs surgery.*

(124) Survivor. *A member who meets the requirements of subsection 22 CSR 10-3.020(6)(A).]*

[(125)](69) Termination of coverage. The termination of medical, dental, or vision coverage initiated by the employer or required by MCHCP eligibility policies.

[(126)] Urgent care. *Medically necessary services in order to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available.*

*Urgent care is appropriate for injuries too severe to be seen in a primary care physician office but not severe enough to require treatment in a hospital emergency department.*

*(127) Urgent care centers. Medical facilities that provide extended or twenty-four (24)-hour service to treat minor conditions at a lower cost than emergency room treatment.]*

*[(128)](70) Usual, [C]customary, and [R]reasonable [charge]. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.*

*[(A) Usual—The fee a provider most frequently charges the majority of his/her patients for the same or similar services.*

*(B) Customary—The range of fees charged in a geographic area by providers of comparable skills and qualifications for the same performance of similar service.*

*(C) Reasonable—The flexibility to take into account any unusual clinical circumstances involved in performing a particular service.*

*(D) A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the providers for ninety percent (90%) of the procedures reported.*

*(129) Utilization review. Evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities on a prospective, concurrent, or retrospective basis.]*

*[(130)](71) Vendor. The current applicable third-party administrators of MCHCP benefits.*

*[(131) Vested subscriber. A member who meets the requirements of subsection 22 CSR 10-3.020(6)(B).]*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED RESCISSION**

**22 CSR 10-3.020 Subscriber Agreement and General Membership Provisions.** This rule established the policy of the

board of trustees in regard to the subscriber agreement and general membership provisions of the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded and readopted to include detailed language to clarify general membership provisions.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency rescission filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Rescinded: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED RULE**

**22 CSR 10-3.020 General Membership Provisions**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the general membership provisions of the Missouri Consolidated Health Care Plan.*

(1) Terms and Conditions. The following rules provide the terms and conditions for membership in the Missouri Consolidated Health Care Plan (MCHCP). Public entities and members are required to provide complete, true, and accurate information to MCHCP in connection with enrollment, change, or cancellation processes, whether by online, written, or verbal communication. MCHCP may rely on, but reserves the right to audit, any information provided by a public entity or member and seek recovery and/or pursue legal action to the extent the public entity or member has provided incomplete, false, or inaccurate information.

(2) Eligibility Requirements.

(A) Employee and Dependent Eligibility Requirements. Health plans contracted with MCHCP must be made available to all eligible employees, their dependents, and retirees of the public entity. An eligible employee is one who is actively employed and meets the minimum number of hours worked per year as established by his/her employer. If the public entity allows elected/appointed officials to participate in medical coverage, the definition of an employee includes elected/appointed officials where applicable. The entity will determine the eligibility requirements of waiting periods, required number of working hours, pay status, and contribution levels.

(B) An employee cannot be covered as an employee and as a dependent.

1. An eligible employee may enroll eligible dependents as long as the eligible employee is also enrolled. Eligible dependents

include:

A. Spouse.

(I) A public entity retiree may enroll as a spouse under an employee's coverage or elect coverage as a retiree.

(II) If one spouse is a state employee with MCHCP benefits and the other is a public entity employee with MCHCP benefits, each spouse may enroll under his or her employer's plan or together under one employer's plan. The spouses cannot have coverage in both places; and

B. Children.

(I) Children may be covered through the end of the month in which they turn twenty-six (26), if they meet one of the following criteria:

- (a) Natural child of subscriber or spouse;
- (b) Legally adopted child of subscriber or spouse;
- (c) Child legally placed for adoption of subscriber or spouse;

(d) Stepchild of subscriber or spouse;

(e) Foster child of subscriber or spouse;

(f) Grandchild for whom the covered subscriber or covered spouse has legal guardianship or legal custody;

(g) A child for whom the subscriber or spouse is the court-ordered legal guardian under a guardianship of a minor. Such child will continue to be considered a dependent child after the guardianship ends by operation of law when the child becomes eighteen (18) years of age if the guardianship of a minor relationship between the subscriber or spouse and the child was in effect the day before the child became eighteen (18) years of age;

(h) Newborn of a subscriber or a covered dependent;

(i) Child for whom the subscriber or covered spouse is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); or

(j) Child who is twenty-six (26) or older and is permanently disabled in accordance with subsection (5)(C) only if such child was an MCHCP member the day before the child turned twenty-six (26).

(II) A child may only be covered by one (1) parent if his/her parents are married and are both covered under an MCHCP medical plan.

(III) A child may have dual coverage if the child's parents are divorced or have never married, and both have coverage under an MCHCP medical plan. MCHCP will only pay for a service once, regardless of whether the claim for the child's care is filed under multiple subscribers' coverage. If a child has coverage under two (2) subscribers, the child will have a separate deductible, copayment, and coinsurance under each subscriber. MCHCP will process the claim and apply applicable cost-sharing using the coverage of the subscriber who files the claim first. The second claim for the same services will not be covered. If a provider files a claim simultaneously under both subscribers' coverage, the claim will be processed under the subscriber whose birthday is first in the calendar year. If both subscribers have the same birthday, the claim will be processed under the subscriber whose coverage has been in effect for the longest period of time.

(C) Changes in Dependent Status. If a covered dependent loses his/her eligibility, the public entity and subscriber must notify MCHCP within thirty-one (31) days to terminate his/her coverage effective the end of the month eligibility ceases.

(D) Retiree and Dependent Eligibility Requirements. A retiree and his/her dependents will remain eligible as long as the entity remains with MCHCP.

1. To enroll or continue coverage at retirement, the employee and his/her dependents must provide all of the following:

A. Submit a completed enrollment form within thirty-one (31) days of retirement date. Coverage is effective on retirement date.

(I) Submit proof of prior coverage and proof of eligibility for dependents if s/he and his/her dependents choose to enroll in an MCHCP plan at retirement and have had other insurance coverage

for six (6) months immediately prior to his/her retirement.

2. Employees may continue coverage on their eligible dependents into retirement.

3. A retiree may only add dependents to his/her coverage when—

A. A life event occurs; or

B. A dependent's employer-sponsored coverage ends due to one (1) of the following, provided that the dependent's employer-sponsored coverage was in place for twelve (12) months immediately prior to the loss, and MCHCP coverage is requested within sixty (60) days of the termination date of the previous coverage:

(I) Termination of employment;

(II) Retirement; or

(III) Termination of group coverage by the employer.

4. A retiree and/or his/her dependents may continue dental and/or vision coverage into retirement without medical coverage.

(3) Enrollment Procedures.

(A) New Employee. The public entity must enroll or waive coverage by submitting the appropriate enrollment form signed by the employee within thirty-one (31) days of his/her eligibility date. A new employee's coverage begins on the first day of the month after the hire date and the applicable waiting period.

(B) Open Enrollment.

1. An employee may elect coverage and/or change coverage levels during the annual open enrollment period if one (1) of the following occurred:

A. Waived his/her right to insurance when first eligible;

B. Did not enroll eligible dependents when first eligible; or

C. Dropped his/her or dependent coverage during the year.

2. A retiree may change from one medical plan to another during open enrollment but cannot add a dependent. If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in a plan during open enrollment.

(C) Special Enrollment Periods.

1. An employee may apply for coverage for himself/herself or for his/her dependents if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of adopted children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. An employee and his/her dependents may enroll within sixty (60) days if s/he involuntarily loses employer-sponsored coverage under one (1) of the following circumstances, and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. A retiree may apply for dependent coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of adopted children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her dependent within sixty (60) days if the dependent involuntarily loses employer-sponsored coverage under one (1) of the following circumstances. Dependent employer-sponsored coverage must be in place for twelve (12) months immediately prior to the loss, and MCHCP coverage must be requested within sixty (60) days of the termination date of the previous coverage:

(I) Employer-sponsored medical, dental, or vision plan terminates;



- (II) Eligibility for employer-sponsored coverage ends;
- (III) Employer contributions toward the premiums end; or
- (IV) COBRA coverage ends.

3. MO HealthNet or Medicaid status loss. If an employee who is not retired, survivor, or his/her dependent loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss.

4. Qualified Medical Child Support Order. If a subscriber receives a court order stating s/he is responsible for coverage of dependent, the subscriber may enroll the dependent(s) in an MCHCP plan within sixty (60) days of the court order.

5. If an active employee has elected coverage as a dependent of another MCHCP subscriber as allowed by these rules, and the subscriber dies before coverage as a dependent goes into effect, the active employee may elect coverage as a subscriber within thirty-one (31) days of the date of death.

(4) Effective Date Provision. In no circumstances can the effective date be before the eligibility date. The effective date of coverage shall be determined, subject to the effective date provisions as follows:

(A) Employee and Dependent Effective Dates.

1. A new employee and his/her eligible dependent(s), or an employee rehired after his/her coverage terminates, and his/her eligible dependent(s) are eligible to participate in the plan on the first day of the month following the employee's eligibility date as determined by the employer.

2. Except at initial employment, an employee and his/her eligible dependents' effective date of coverage is the first of the month coinciding with, or after the eligibility date and applicable waiting period. The effective date of coverage cannot be prior to the date of receipt of the enrollment by MCHCP except for newborns.

3. The effective date of coverage for a life event shall be as follows:

A. If enrollment by an employee is made before a wedding date, spouse's coverage becomes effective on the wedding date. The monthly premium is not prorated;

B. If enrollment by an employee is made within thirty-one (31) days of a wedding date, spouse's coverage becomes effective the first of the month coinciding with or after receipt of the enrollment form and proof of eligibility;

C. If enrollment by a subscriber is made for a newborn of a member, the effective date for the newborn is the birth date. If enrollment is made by an employee due to the birth of a newborn of the employee, the effective date for the employee and newborn is the first of the month coinciding with or after enrollment is received;

D. If enrollment by an employee is made within thirty-one (31) days after the eligibility date, for an adoption, or placement of adopted children, coverage becomes effective on the eligibility date or the first day of the calendar month coinciding with or after the date the enrollment is received; or

E. If enrollment by an employee is made due to legal guardianship of a dependent within thirty-one (31) days of guardianship effective date, the effective date for the dependent is the first day of the calendar month coinciding with or after the date the enrollment is received.

4. An employee and his/her eligible dependent(s) who elect coverage and/or change coverage levels during open enrollment shall have an effective date of January 1 of the following year.

5. When a dependent of a subscriber first becomes eligible, coverage will become effective on the eligibility date or the first day of the month coinciding with or after the eligibility date if enrollment is made within thirty-one (31) days of the eligibility date.

6. A Qualified Medical Child Support Order is effective the first of the month coinciding with or after the form is received by the plan or date specified by the court.

(5) Proof of Eligibility.

(A) A public entity is required to obtain and keep on file proof of eligibility for dependents enrolled in a MCHCP medical, dental, and/or vision plan. Proof of eligibility documentation is required for all dependents.

1. Notification of the proof of eligibility policy will occur during the September 2012 public entity payroll representatives' informational meetings. Initial time frame for a public entity to obtain proof of eligibility documentation will occur September 1, 2012, through November 29, 2012.

2. Proof of eligibility must be obtained within thirty-one (31) days for a newly enrolled dependent and within ninety (90) days from date of birth for a newborn.

3. Coverage is provided for a newborn of a member from the moment of birth. The public entity or member must notify the plan of the birth verbally or in writing within thirty-one (31) days of the birth date. The plan will notify the public entity and member of the steps to continue coverage. The member is allowed an additional ten (10) days from the date of the plan notice to return the enrollment form. Coverage will not continue unless the enrollment form is received within thirty-one (31) days of the birth date or ten (10) days from the date of the notice, whichever is later.

4. MCHCP reserves the right to request proof of eligibility be provided at any time. If such proof is not received or is unacceptable as determined by MCHCP, coverage for the applicable dependent will be terminated or will not take effect.

5. Documentation is also required when a subscriber attempts to terminate a dependent's coverage in the case of divorce or death.

6. Acceptable forms of proof of eligibility are included in the following chart:

<b>Circumstance</b>	<b>Documentation</b>
Birth of dependent(s)	Government-issued birth certificate or other government-issued or legally-certified proof of eligibility listing subscriber as parent and newborn's full name and birth date
Addition of step-child(ren)	Marriage license to biological or legal parent/guardian of child(ren); and government-issued birth certificate or other government-issued or legally-certified proof of eligibility for child(ren) that names the subscriber's spouse as a parent or guardian and child's full name and birth date
Addition of foster child(ren)	Placement papers in subscriber's care
Adoption of dependent(s)	Adoption papers; Placement papers; or Filed petition for adoption; and Lists subscriber as adoptive parent
Legal guardianship of dependent(s)	Court-documented guardianship papers listing member as guardian (Power of Attorney is not acceptable)
Newborn of covered dependent	Government-issued birth certificate or legally-certified proof of eligibility for newborn listing covered dependent as parent with newborn's full name and birth date
Marriage	Marriage license or certificate recognized by Missouri law
Divorce	Final divorce decree; or Notarized letter from spouse stating s/he is agreeable to termination of coverage pending divorce or legal separation
Death	Death certificate
Loss of MO HealthNet or Medicaid	Letter from MO HealthNet or Medicaid stating who is covered and the date coverage terminates
MO HealthNet Premium Assistance	Letter from MO HealthNet or Medicaid stating member is eligible for the premium assistance program
Qualified Medical Child Support Order	Qualified medical child support order
Prior Group Coverage	Letter from previous insurance carrier or former employer stating date coverage terminated, reason for coverage termination, and list of dependents covered

7. Annually, MCHCP will require a signed attestation form verifying receipt of proof of eligibility from the public entity with enrolled dependents. A blank attestation form will be delivered to the public entity prior to open enrollment. Instructions to complete the form, filing requirements, and deadlines will accompany the attestation form.

(B) The employee is required to notify MCHCP on the appropriate form of the dependent's name, date of birth, eligibility date, and Social Security number.

(C) Permanently disabled children will continue to be eligible beyond age twenty-six (26) during the continuance of a permanent disability, provided the following documentation is submitted to the public entity prior to the dependent's twenty-sixth birthday:

1. The Supplemental Security Income (SSI) Notice of Award from the Social Security Administration (SSA) verifying the dependent is entitled to and receiving disability benefits as of a specific date;

2. A letter from the dependent's physician describing the dis-

ability and verifying that the disability pre-dates the SSA determination; and

3. A current benefit verification letter from the SSA confirming the dependent is still considered disabled by SSA.

(D) Members who are eligible for Medicare benefits under Part A, B, or D must notify MCHCP of their eligibility and provide a copy of the member's Medicare card within thirty-one (31) days of the Medicare eligibility date. Claims will not be processed until the required information is provided.

(6) Military Leave.

(A) Military Leave for an Employee who is not Retired.

1. For absences of thirty (30) days or less, coverage continues as if the employee has not been absent.

2. For absences of thirty-one (31) days or more, coverage ends unless the employee elects to pay for COBRA coverage. The agency payroll representative notifies MCHCP of the effective date of military leave.

3. If the employee is utilizing annual and/or compensatory balances and staying on payroll, the dependent coverage is at the active employee monthly premium.

4. If the employee does not elect to continue COBRA coverage for his/her eligible dependent(s), coverage ends effective the last day of the month in which the leave begins.

5. The former employee must submit a form within thirty-one (31) days of the employee's return to work for the same level of coverage with the same plan to be reinstated. The former employee must submit a form and an official document indicating the separation date if s/he elects coverage after thirty-one (31) days of returning to work.

6. Coverage may be reinstated the first of the month in which the member returns to employment, the first of the month after return to employment, or the first of the month after the loss of military coverage.

**(B) Military Leave for a Retired Member.**

1. A retiree must terminate his/her coverage upon entry into the armed forces of any country by submitting a form and copy of his/her activation papers within thirty-one (31) days of his/her activation date.

2. Coverage will be terminated the last day of the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of his/her separation papers and form within thirty-one (31) days of the separation date.

3. Coverage will be reinstated as of the first of the month in which the employee returns from active duty, the first of the month after the employee returns or the first of the month after the loss of military coverage.

4. If the retired member fails to reinstate coverage, s/he cannot enroll at a later date.

5. If the employee terminates his/her coverage, dependent coverage is also terminated.

**(7) Termination.**

(A) Termination of coverage shall occur on the last day of the calendar month coinciding with or after the happening of any of the following events, whichever shall occur first:

1. Failure to make any required contribution toward the cost of coverage;

2. Entry into the armed forces of any country as defined in section (6);

3. With respect to employees, termination of coverage shall occur upon termination of employment, except as expressly specified otherwise in this rule. Termination of employee's coverage shall terminate the coverage of dependents;

4. With respect to dependents, termination of coverage shall occur upon divorce or legal separation from the subscriber or when a child reaches age twenty-six (26). A subscriber must terminate coverage for his/her spouse and stepchild(ren) at the time his/her divorce is final.

A. The public entity shall notify MCHCP when any of subscriber's dependents cease to be a dependent as defined in this chapter;

5. Death of dependent. The dependent's coverage ends on the date of death.

A. The public entity shall notify MCHCP of a dependent's death;

6. Termination due to a member's act, practice, or omission that constitutes fraud or the member makes an intentional misrepresentation of material fact;

7. Termination due to a member's threatening conduct or perpetrating violent acts against MCHCP or an employee of MCHCP;

8. A rescission will apply only to non-payment of a premium, fraud, or intentional misrepresentation. MCHCP shall provide at least thirty (30) days written notice before it rescinds coverage;

9. Termination of coverage shall occur immediately upon discontinuance of the plan subject to the plan termination provision specified in 22 CSR 10-3.080(1); and

10. If a member receives covered services after the termination of coverage, MCHCP may recover the contracted charges for such covered services from the subscriber or the provider, plus its cost to recover such charges, including attorneys' fees.

**(8) Voluntary Cancellation of Coverage.**

(A) A subscriber may cancel medical coverage, which will be effective on the last day of the month in which the form is received by MCHCP, unless the subscriber notifies MCHCP on the first calendar day of the month; then cancellation of coverage is effective the last day of the previous month.

1. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, the subscriber may only cancel medical coverage if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.

(B) A subscriber may retroactively cancel coverage on his/her spouse to be effective on the last day of the month in which a divorce is final. A copy of the divorce decree must accompany the change request.

(C) If a member receives covered services after the voluntary cancellation of coverage, MCHCP may recover the contracted charges for such covered services from the subscriber or the provider, plus its cost to recover such charges, including attorneys' fees.

(D) A subscriber may only cancel dental and/or vision coverage during the year for themselves or their dependents for one (1) of the following reasons:

1. Upon retirement; or
2. When beginning a leave of absence.

**(9) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).**

(A) Eligibility. In accordance with COBRA, eligible employees and their dependents may temporarily continue their coverage when coverage under the plan would otherwise end. Coverage is identical to the coverage provided under MCHCP to similarly situated employees and family members. If members cancel COBRA coverage, they cannot enroll at a later date.

1. Employees voluntarily or involuntarily terminating employment (for reasons other than gross misconduct) or receiving a reduction in the number of hours of employment may continue coverage for themselves and their covered dependent(s) for eighteen (18) months at their own expense.

2. If a subscriber marries, has a child, or adopts a child while on COBRA coverage, eligible dependents can be added to the subscriber's plan upon notification to MCHCP. The subscriber may also add eligible dependents during open enrollment.

3. Dependents may continue coverage for up to thirty-six (36) months at their own expense if the covered employee becomes eligible to Medicare.

4. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

5. A divorced spouse and dependents may continue coverage at their own expense for up to thirty-six (36) months.

6. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense.

7. If the Social Security Administration determines a COBRA member is disabled within the first sixty (60) days of coverage, the member may continue coverage for up to twenty-nine (29) months.

8. An employee who is on military leave is eligible for continued coverage for medical and dental care for the lesser of: a) twenty-four (24) months beginning on the date the leave begins; or b) the day after the date the employee fails to apply for or return to their position of employment following leave.

9. If the eligible member has Medicare prior to becoming eligible for COBRA coverage, the member is entitled to coverage under both.

**(B) Premium Payments.**

1. Initial payment for continuation coverage must be received within forty-five (45) days of election of coverage.

2. After initial premium payment, MCHCP bills on the last working day of the month. There is a thirty-one (31) day grace period for payment of regularly scheduled monthly premiums.

3. Premiums for continued coverage will be one hundred two percent (102%) of the total premium for the applicable coverage level. Once coverage is terminated under the COBRA provision, it cannot be reinstated.

**(C) Required Notifications.**

1. The subscriber or applicable member must notify MCHCP of a divorce, legal separation, a child turning age twenty-six (26), or Medicare entitlement within sixty (60) days of the event date.

2. The human resource/payroll office of the subscriber must notify MCHCP of an employee's death, termination, or reduction of hours of employment.

**(D) Election Periods.**

1. When MCHCP is notified that a COBRA-qualifying event has occurred, MCHCP notifies eligible members of the right to choose continuation coverage.

2. Eligible members have sixty (60) days from the date of coverage loss or notification from MCHCP, whichever is later, to inform MCHCP that they want continuation coverage.

3. If eligible members do not choose continuation coverage within sixty (60) days of lost coverage or notification from MCHCP, coverage ends.

**(E) Continuation of coverage may be cut short for any of these reasons—**

1. The state of Missouri no longer provides group health coverage to any of its employees;

2. Premium for continuation coverage is not paid on time;

3. The covered employee or dependent becomes covered (after the date s/he elects COBRA coverage) under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition s/he may have;

4. The covered employee or dependent becomes entitled to Medicare after the date s/he elects COBRA coverage; or

5. The covered employee or dependent extends coverage for up to twenty-nine (29) months due to disability and there has been a final determination that the individual is no longer disabled.

**(F) MCHCP assumes coverage for existing COBRA members until their eligibility period expires or until the public entity terminates coverage with MCHCP, whichever occurs first.**

**(10) Missouri State Law COBRA Wrap-Around Provisions.**

(A) Missouri law provides that if a member loses group health insurance coverage because of a divorce, legal separation, or the death of a spouse, the member may continue coverage until age sixty-five (65) under two (2) conditions—

1. The member continues and maintains coverage under the thirty-six (36)-month provision of COBRA; and

2. The member is at least fifty-five (55) years old when COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay the entire premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium.

**(B) If continuation coverage is not chosen within the proper time frames listed below, continuation of coverage ends—**

1. Within sixty (60) days of legal separation or the entry of a decree of dissolution of marriage or prior to the expiration of a thirty-six (36)-month COBRA period, the legally separated or divorced spouse who seeks such coverage shall give MCHCP written notice of the qualifying event, including his/her mailing address;

2. Within thirty (30) days of the death of an employee whose surviving spouse is eligible for continued coverage or prior to the expiration of a thirty-six (36) month COBRA period, the human resource/payroll representative shall give MCHCP written notice of

the death and the mailing address of the surviving spouse; or

3. Within fourteen (14) days of receipt of the notice, MCHCP shall notify the legally separated, divorced, or surviving spouse that coverage may be continued. The notice shall include:

A. A form for election to continue the coverage;

B. The amount of premiums to be charged and the method and place of payment; and

C. Instructions for returning the elections form by mail within sixty (60) days after MCHCP mails the notice.

**(C) Continuation of coverage terminates on the last day of the month prior to the month the subscriber turns age sixty-five (65). The right to continuation coverage shall also terminate upon the earliest of any of the following:**

1. The state of Missouri no longer provides group health coverage to any of its employees;

2. Premium for continuation coverage is not paid on time;

3. The date on which the legally separated, divorced, or surviving spouse becomes insured under any other group health plan;

4. The date on which the legally separated, divorced, or surviving spouse remarries and becomes insured under another group health plan; or

5. The date on which the legally separated, divorced, or surviving spouse reaches age sixty-five (65).

**(11) Medicare.**

(A) If a member does not enroll in Medicare when s/he is eligible and Medicare should be the member's primary plan, the member will be responsible for paying the portion Medicare would have paid. An estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim-submitted basis so that if, for a given claim, Medicare reimbursement would be for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims for this plan's deductible and out-of-pocket maximum expenses.

(B) MCHCP's prescription drug plan is evaluated by a third party to determine whether it is creditable and considered equal to or better than Medicare Part D. The member will receive notification of the outcome from MCHCP. If MCHCP's plan is considered creditable, the member does not need to enroll in Medicare Part D and will not be penalized if s/he signs up for Part D at a later date.

(C) If a member enrolls in a Medicare Part D plan in addition to coverage under this plan, Medicare Part D becomes the member's primary plan. Such member's benefit must be adjusted in order for the plan to avoid liability for filing claims under the subsidy reimbursement portion of Medicare Part D. This plan will pay primary with appropriate copayments or coinsurance when the member is within the donut hole.

**(12) Communications to Members.**

(A) It is the member's responsibility to ensure that MCHCP has current contact information for the member and any dependent(s).

(B) A member must notify MCHCP of a change in his/her mailing or email address as soon as possible, but no later than thirty-one (31) days after the change.

(C) It is the responsibility of all members who elect to receive plan communication through email to ensure plan emails are not blocked as spam or junk mail by the member or by the member's service provider.

(D) Failure to update a mailing or email address may result in undeliverable mail/email of important informational material, delayed or denied claims, loss of coverage, loss of continuation rights, missed opportunities relating to covered benefits, and/or liability for claims paid in error.

**(13) Deadlines.** Unless specifically stated otherwise, MCHCP computes deadlines by counting day one as the first day after the qualifying event. If the last day falls on a weekend or state holiday, the

plan administrator may receive required information on the first working day after the weekend or state holiday.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the **Code of State Regulations**. Emergency rescission and rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Rescinded and readopted: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rule will cost state agencies or political subdivisions \$3,593,202 in the aggregate.*

*PRIVATE COST: This proposed rule will cost private entities \$4,895,873 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Name:</b>	<b>22 CSR 10-3.020 General Membership Provisions</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003</b>	<b>\$3,593,202</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the Active Employee Only public entity premium for all public entity employees who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under the all public entity plans as of August 1, 2011;
- Calendar year 2012 membership in the public entity plans remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Calculations assume each public entity is contributing 50 percent of the Active Employee Only premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual claim costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.020 General Membership Provisions</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>1,403 individuals enrolled in MCHCP public entity plans for CY 2012</b>	<b>Individuals enrolled in MCHCP public entity plans for CY 2012</b>	<b>\$4,895,873</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the Active Employee Only public entity premium, plus 100 percent of the additional premium for other levels of coverage for all public entity employees who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under all public entity plans as of August 1, 2011;
- Calendar year 2012 membership in the all public entity plans remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Calculations assume each public entity is contributing 50 percent of the Active Employee Only premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-3.030 Public Entity Membership Agreement and Participation Period.** The Missouri Consolidated Health Care Plan is deleting sections (2), (3), (5), and (6); amending sections (1) and (7); adding section (3); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the Public Entity Membership Agreement and Participation Period of the Missouri Consolidated Health Care Plan.*

(1) The *[application packet,]* participation agreement, *[and confirmation notice shall comprise]* **these rules, and applicable provisions of law constitute** the membership agreement between a public entity and the Missouri Consolidated Health Care Plan (MCHCP).

(A) By applying for coverage under *[the]* MCHCP, a public entity agrees that—

1. *[The]* MCHCP will be the only health care offering made to its eligible members;

2. The public entity shall contribute at least fifty percent (50%) of the lowest cost employee only premium per month toward each active employee's premium for the plan(s) offered through MCHCP;

3. **The public entity shall contribute at least fifty percent (50%) toward the employee-only dental premium per month. One hundred percent (100%) of the employees and fifty percent (50%) of dependents covered by the medical plan must participate in the dental plan. The number of members in the dental plan must meet or exceed the number in the medical plan, but the same employees do not have to be enrolled in the plans;**

4. **There are no participation or contribution requirements for vision coverage;**

5. **The Employee Assistance Program is paid by the employer and requires one hundred percent (100%) participation of employees eligible for medical coverage and can be expanded to additional classifications;**

*[3.]/6.* For public entities with *[less]* fewer than twenty-five (25) employees, the public entity shall only offer one (1) MCHCP medical plan choice to its employees. For public entities with twenty-five (25) or more employees, the public entity may offer two (2) MCHCP medical plans provided by MCHCP;

*[4.]/7.* For public entities with more than a total of three (3) employees, at least seventy-five percent (75%) of all eligible employees must *[join the]* enroll in MCHCP. If an employee declines coverage, s/he must submit a form stating coverage is waived. If the employee is waiving coverage because s/he is covered under another group health plan, or has Medicare or Medicaid, the employee must submit proof of other coverage. An employee with other group coverage, Medicare, or Medicaid is exempt from the seventy-five percent (75%) enrollment participation requirement;

*[5. Individual and family deductibles, if applicable, will be applied. Deductibles previously paid to meet the requirements of the terminating plan may be credited for those joining MCHCP. Appropriate proof of said deductibles will be required;]*

*[6.]/8.* An eligible employee is one *[that]* who is not covered by another group sponsored plan;

*[7.]/9.* Any individual eligible as an employee may be covered as either an employee or dependent, but not both. Employees enrolled as dependents will not be considered as eligible employees *[in consideration of section (6)]*; and

*[8.]/10.* A public entity may apply a probationary period, not to exceed applicable federal guidelines, before benefits become effective.

tive.

(B) In order to provide retiree coverage, any participating member agency joining MCHCP must have one (1) of the criteria listed below. *[If neither of these scenarios is applicable and no retirement plan exists, no "retirees" would exist, so there would be no retiree eligibility.]*

1. An established retirement plan with contributions shared by both the employee and the employer (or made by the employer only) with an established minimum vesting period. The employer must offer coverage to retirees who have met this minimum vesting period requirement.

2. An employer-sponsored (but no contribution made by employer) retirement plan in which the employee is currently participating or from which the employee is eligible to receive a benefit. In this case, in order to be considered an eligible retiree, the prospective member must have met a vesting criterion equal to Missouri State Employees' Retirement System (MOSERS). If this criterion was not met, the employer may not offer coverage to that person as a retiree.

*[(2) The public entity's participation period shall begin on the date specified in the participation agreement. Participation shall continue until the end of the participation agreement is reached or immediately upon discontinuance of the plan subject to the plan termination provision specified in 22 CSR 10-3.080(1).]*

*[(3) The voluntariness of the public entity's failure to meet participation levels is to be determined by MCHCP. Examples of non-voluntary failure to meet participation levels include: 1) a public entity falls below the required participation level due to employment termination(s); and 2) a public entity falls below the required participation level, but the public entity can prove that all eligible employees who failed to take the coverage have other group coverage not offered through the public entity or are Medicare eligible.]*

*[(4)](2)* Total premium costs for *[various classes]* coverage levels of employee participation, based on employment status, eligibility for Medicare, and for various classifications of dependent participation, are established by the plan administrator.

**(3) Premiums. Premiums are billed the fifteenth day of the current month for the next month's coverage.**

(A) If a retiree or COBRA member is delinquent for two (2) months of premiums and payment is not received by the fifteenth of the month following the delinquency, coverage will be terminated for nonpayment retroactive to the last day of the month for which full premium was received (example: Bill sent September 15 for October premiums and no payment was received; bill mailed October 15 for October and November premiums, due on November 15. If payment is not received, coverage will be terminated due to nonpayment effective September 30). The member will be responsible for the re-payment of the services rendered after the retroactive termination date.

(B) If a public entity is delinquent for one (1) month of premiums and the delinquent payment is not received at the end of the month for the month of coverage, coverage for members is terminated for nonpayment on the last day of the month for which full premium was received (example: Bill sent September 15 for October premiums and no payment was received; bill mailed October 15 for November premiums due November 15 and October delinquent premiums due on October 31. If the October premium is not received by October 31, coverage will be terminated due to nonpayment effective September 30). The public entity will be responsible for re-payment of the services rendered after the retroactive termination date. A termination of coverage resulting from nonpayment will not relieve the public entity of



obligations assumed by the public entity in the Amended and Restated Participation Agreement and under state law. Moneys are due to MCHCP upon or following termination pursuant to Chapter 103, RSMo.

*[(5) Underwriting guidelines are set by the plan administrator.*

*(6) The contribution by the employee shall be determined, within the underwriting guidelines set by the plan administrator, by the appropriate administrative unit for the public entity.]*

*[(7)](4) Refunds of overpayments are limited to the amount overpaid during the twelve (12)-month period [ending at the end of the month] preceding the month during which notice of overpayment is received.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions \$3,593,202 in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities \$4,895,873 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Name:</b>	<b>22 CSR 10-3.030 Public Entity Membership Agreement and Participation Period</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003</b>	<b>\$3,593,202</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the Active Employee Only public entity premium for all public entity employees who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under the all public entity plans as of August 1, 2011;
- Calendar year 2012 membership in the public entity plans remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Calculations assume each public entity is contributing 50 percent of the Active Employee Only premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual claim costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.030 Public Entity Membership Agreement and Participation Period</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>1,403 individuals enrolled in MCHCP public entity plans for CY 2012</b>	<b>Individuals enrolled in MCHCP public entity plans for CY 2012</b>	<b>\$4,895,873</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the Active Employee Only public entity premium, plus 100 percent of the additional premium for other levels of coverage for all public entity employees who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under all public entity plans as of August 1, 2011;
- Calendar year 2012 membership in the all public entity plans remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Calculations assume each public entity is contributing 50 percent of the Active Employee Only premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-3.045 Plan Utilization Review Policy.** The Missouri Consolidated Health Care Plan is amending section (1).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the Plan Utilization Review Policy of the Missouri Consolidated Health Care Plan.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program has the following components:

(A) Prior *[a]* Authorization of *[s]* Services—The claims administrator must authorize some services in advance. Without prior authorization, any claim that requires prior authorization will not be covered. *[Participants]* **Members** who have another primary carrier, including Medicare, are not subject to this provision. Prior authorization does not verify eligibility or payment. Prior authorizations based on a material misrepresentation or intentional or negligent omission about the person's health condition or the cause of the condition will not be covered.

1. The following medical services are subject to prior authorization:

A. Ambulance services for non-emergent *[cy]* use whether air or ground;

**B. Anesthesia and hospital charges for dental care for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization;**

*[B.]C.* Applied behavior *[a]* analysis for autism;

**D. Auditory brainstem implant (ABI);**

**E. Bariatric procedures;**

*[C.]F.* Cardiac and pulmonary rehabilitation after thirty-six (36) visits within a twelve (12)-week period;

*[D.]G.* Chiropractic services after twenty-six (26) visits annually;

*[E.]H.* Cochlear implant device;

**I. Chelation therapy;**

*[F.]J.* Dental care to reduce trauma and restorative services when the result of accidental injury;

*[G.]K.* Durable medical equipment (DME) over one thousand five hundred dollars (\$1,500) or DME rentals over five hundred dollars (\$500) per month;

*[H.]L.* Genetic testing or counseling;

*[I.]M.* Home health care and palliative services;

*[J.]N.* Hospice care;

*[K.]O.* Hospital inpatient services except for observation stays;

*[L.]P.* Maternity coverage for maternity hospital stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery;

*[M.]Q.* Nutritional counseling after three (3) sessions annually;

*[N.]R.* Orthotics over one thousand dollars (\$1,000);

*[O.]* Oxygen provided on an outpatient basis;

*[P.]S.* Physical, speech, and occupational therapy and rehabilitation services (outpatient) after sixty (60) combined visits per incident;

**T. Procedures with codes ending in "T";**

*[Q.]U.* Prostheses over one thousand dollars (\$1,000);

*[R.]V.* Skilled nursing facility;

*[S.]W.* Surgery (outpatient)—The following outpatient surgical procedures: **cornea transplant**, potential cosmetic surgery, sleep

apnea surgery, implantable stimulators, **stimulators for bone growth**, surgeries with procedure codes ending in "T" (temporary codes used for data collection, experimental, investigational, or unproven surgeries), spinal surgery (including, but not limited to, artificial disc replacement, fusions, nonpulsed radiofrequency denervation, vertebroplasty, kyphoplasty, spinal cord stimulator trials, spinal cord stimulator implantation, and any unlisted spinal procedure), and oral surgery (excisions of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological exams); *[Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth; reduction of fractures and dislocations of the jaw; excision of exostosis of jaws and hard palate; external incisions and drainage of cellulitis; incision of accessory sinuses, salivary glands, or ducts; or frenectomy];* and

*[T.]X.* Transplants including requests related to covered travel and lodging.

2. The following pharmacy services are subject to prior authorization:

A. Second-step therapy medications that skip the first-step medication trial;

B. Specialty medications *[. Drugs that treat chronic, complex conditions such as hepatitis C, multiple sclerosis, and rheumatoid arthritis. The specialty medication requires frequent dosage adjustments, clinical monitoring, and special handling and are often unavailable at retail pharmacies. The specialty medication must be filled through the claims administrator's home delivery pharmacy provider];*

C. Medications that may be prescribed for several conditions, including some *[where]* for which treatment is not medically necessary;

D. Medication refill requests that are before the time allowed for refill;

E. Medications that exceed drug quantity and day supply limitations; and

F. The cost of the medication exceeds nine thousand nine hundred ninety-nine dollars and ninety-nine cents (\$9,999.99) at retail pharmacy, one thousand four hundred ninety-nine dollars and ninety-nine cents (\$1,499.99) at mail order, and one hundred forty-nine dollars and ninety-nine cents (\$149.99) for compound medications.

3. Prior authorization time frames.

A. A benefit determination for non-urgent prior authorization requests will be made within fifteen (15) calendar days of the receipt of the request. The fifteen (15) days may be extended by the claims administrator for up to fifteen (15) calendar days if an extension is needed as a result of matters beyond the claims administrator's control. The claims administrator will notify the member of any necessary extension prior to the expiration of the initial fifteen (15)-calendar-day period. If a member fails to submit necessary information to make a benefit determination, the member will be given at least forty-five (45) calendar days from receipt of the extension notice to respond with additional information.

B. A benefit determination for urgent prior authorization requests will be made as soon as possible based on the clinical situation, but in no case later than twenty-four (24) hours of the receipt of the request;

(B) Concurrent Review—The claims administrator will monitor the medical necessity of the inpatient admission to certify the necessity of the continued stay in the hospital. *[Participants]* **Members** who have another primary carrier, including Medicare, are not subject to this provision; and

(C) Retrospective Review—Reviews conducted after services have been provided to a patient. The retrospective review **does not** include *[s]* the review of a claim that is limited to an evaluation of reimbursement levels, accuracy and adequacy of documentation or coding, or settling of payment.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1)–(4); adding section (5); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the PPO 1000 Plan Benefit Provisions and Covered Charges of the Missouri Consolidated Health Care Plan.*

(1) Deductible amount—Network: per individual each calendar year, one thousand dollars (\$1,000); family *[limit]* each calendar year, three thousand dollars (\$3,000). Non-network: per individual each calendar year, two thousand dollars (\$2,000); family *[limit]* each calendar year, six thousand dollars (\$6,000).

(C) During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and coinsurance. *[The newborn will not be subject to a separate deductible and coinsurance.]* The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital. **If the mother is not a Missouri Consolidated Health Care Plan member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.**

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims[—] are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims[—] are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(D) Claims shall be paid at ninety percent (90%) if required covered services are not available through a network provider within one hundred (100) miles of the member's home. The *[participant/ member]* must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is for three (3) months. After three (3) months, the *[participant/ member]* must contact the claims administrator to reassess network availability.

(E) Preventive care—network claims are paid at one hundred

percent (100%). Non-network claims are paid at seventy percent (70%) coinsurance after the deductible.

(3) Copayments—set charges for the following *[types of claims/ services apply]* as long as network providers are utilized **unless otherwise specified. Copayments do not apply to the deductible or out-of-pocket maximum.**

(A) Office visit—Network: primary care—twenty dollars (\$20), specialist—thirty dollars (\$30); Non-network: seventy percent (70%) coinsurance after deductible.

1. Vision office visit or refraction—thirty dollars (\$30).

2. Hearing test—performed by a primary care physician: twenty dollars (\$20); performed by a specialist: thirty dollars (\$30).

(B) Maternity—Network: primary care—twenty dollars (\$20) for initial visit, specialist—thirty dollars (\$30) for initial visit; **lab-covered at one hundred percent (100%); other diagnostic tests—ninety percent (90%) coinsurance after deductible;** Non-network: **all services paid at** seventy percent (70%) coinsurance after deductible.

*[(C)] Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: seventy percent (70%) coinsurance after deductible.]*

*[(D)](C) Emergency room—Network: one hundred dollar (\$100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar (\$100) copayment (waived if admitted as inpatient).*

*[(E)](D) Urgent care—Network: fifty dollar (\$50) copayment; Non-network: fifty dollar (\$50) copayment.*

(E) Bariatric surgery—five hundred dollar (\$500) copayment and ten percent (10%) coinsurance after deductible is met.

(4) Out-of-pocket maximum—the maximum amount payable by the *[participant/ member]* before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) The family out-of-pocket maximum is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member out-of-pocket maximums may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

*[(A)](C) Network out-of-pocket maximum for individual—four thousand five hundred dollars (\$4,500).*

*[(B)](D) Network out-of-pocket maximum for family—thirteen thousand five hundred dollars (\$13,500).*

*[(C)](E) Non-network out-of-pocket maximum for individual—ten thousand dollars (\$10,000).*

*[(D)](F) Non-network out-of-pocket maximum for family—thirty thousand dollars (\$30,000).*

*[(E)](G) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the *[U]*usual, *[C]*customary, and *[R]*reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.*

(5) Usual, customary, and reasonable fee allowed—non-network medical claims are processed at the eighty-fifth percentile of usual, customary, and reasonable fees as determined by the vendor.

*[(5)](6) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions \$1,077,482 in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities \$1,672,714 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 3**

<b>Rule Number and Name:</b>	<b>22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003</b>	<b>\$1,077,482</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the Active Employee Only public entity premium for the PPO 1000 Plan for all public entity employees who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under the PPO 1000 Plan as of August 1, 2011;
- Calendar year 2012 membership in the PPO 1000 Plan remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Calculations assume each public entity is contributing 50 percent of the Active Employee Only premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual claim costs will vary based upon actual utilization of services.

## FISCAL NOTE PRIVATE COST

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

## II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>471 individuals enrolled in the MCHCP Public Entity PPO 1000 Plan for CY 2012</b>	<b>Individuals enrolled in the MCHCP Public Entity PPO 1000 Plan for CY 2012</b>	<b>\$1,672,714</b>

## III. WORKSHEET

Estimated cost is the annual cost of 50 percent of the Active Employee Only public entity premium, plus 100 percent of the additional premium for other levels of coverage for the PPO 1000 Plan to all public entity employees who enroll for coverage under this plan for calendar year 2012.

## IV. ASSUMPTIONS

- Total enrollment under the PPO 1000 Plan as of August 1, 2011;
- Calendar year 2012 membership in the PPO 1000 Plan remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Calculations assume each public entity is contributing 50 percent of the Active Employee Only premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.



**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1)–(4); adding section (5); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the PPO 2000 Plan benefit provisions and covered charges of the Missouri Consolidated Health Care Plan.*

(1) Deductible amount—Network: per individual each calendar year, two thousand dollars (\$2,000); family *[limit]* each calendar year, six thousand dollars (\$6,000). Non-network: per individual each calendar year, four thousand dollars (\$4,000); family *[limit]* each calendar year, twelve thousand dollars (\$12,000).

(C) During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and coinsurance. *[The newborn will not be subject to a separate deductible and coinsurance.]* The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital. **If the mother is not a Missouri Consolidated Health Care Plan member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.**

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(D) Claims shall be paid at eighty percent (80%) if required covered services are not available through a network provider within one hundred (100) miles of the member's home. The *[participant]* member must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is for three (3) months. After three (3) months, the *[participant]* member must contact the claims administrator to reassess network availability.

**(E) Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: sixty percent (60%) coinsurance after deductible.**

(3) Copayments—set charges for the following *[types of claims so]* services apply as long as network providers are utilized. **Copayments do not apply to the deductible or out-of-pocket maximum.**

(A) Office visit—Network: primary care—twenty-five dollars (\$25), specialist—thirty-five dollars (\$35); Non-network: sixty percent (60%) coinsurance after deductible.

**1. Vision office visit or refraction—thirty-five dollars (\$35).**

**2. Hearing test primary care—twenty-five dollars (\$25); specialist: thirty-five dollars (\$35).**

(B) Maternity—Network: primary care—twenty-five dollars (\$25) for initial visit, specialist—thirty-five dollars (\$35) for initial visit; **lab—covered at one hundred percent (100%); other diagnostic tests—eighty percent (80%) coinsurance after deductible;** Non-network: **all services paid at sixty percent (60%) coinsurance after deductible.**

*[(C) Preventive care—Network: no copayment, covered at one hundred percent (100%); Non-network: sixty percent (60%) coinsurance after deductible.]*

*[(D)](C) Emergency room—Network: one hundred dollar (\$100) copayment (waived if admitted as inpatient); Non-network: one hundred dollar (\$100) copayment (waived if admitted as inpatient).*

*[(E)](D) Urgent care—Network: fifty dollar (\$50) copayment; Non-network: fifty dollar (\$50) copayment.*

**(E) Bariatric surgery—five hundred dollar (\$500) copayment and twenty percent (20%) coinsurance after deductible is met.**

(4) Out-of-pocket maximum—the maximum amount payable by the *[participant]* member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

**(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.**

**(B) The family out-of-pocket maximum is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member out-of-pocket maximums may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.**

*[(A)](C) Network out-of-pocket maximum for individual—six thousand dollars (\$6,000).*

*[(B)](D) Network out-of-pocket maximum for family—eighteen thousand dollars (\$18,000).*

*[(C)](E) Non-network out-of-pocket maximum for individual—twelve thousand dollars (\$12,000).*

*[(D)](F) Non-network out-of-pocket maximum for family—thirty-six thousand dollars (\$36,000).*

*[(E)](G) Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: copayments; claims for services paid at one hundred percent (100%); charges above the *[U]*usual, *[C]*customary, and *[R]*reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.*

**(5) Usual, customary, and reasonable fee allowed—non-network medical claims are processed at the eighty-fifth percentile of usual, customary, and reasonable fees as determined by the vendor.**

*[(5)](6) Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions nine hundred sixty-nine thousand two hundred thirty-five dollars (\$969,235) in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities \$1,212,644 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Name:</b>	<b>22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003</b>	<b>\$ 969,235</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the Active Employee Only public entity premium for the PPO 2000 Plan for all public entity employees who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under the PPO 2000 Plan as of August 1, 2011;
- Calendar year 2012 membership in the PPO 2000 Plan remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Calculations assume each public entity is contributing 50 percent of the Active Employee Only premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual claim costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>404 individuals enrolled in the MCHCP Public Entity PPO 2000 Plan for CY 2012</b>	<b>Individuals enrolled in the MCHCP Public Entity PPO 2000 Plan for CY 2012</b>	<b>\$ 1,212,644</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the Active Employee Only public entity premium, plus 100 percent of the additional premium for other levels of coverage for the PPO 2000 Plan to all public entity employees who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under the PPO 2000 Plan as of August 1, 2011;
- Calendar year 2012 membership in the PPO 2000 Plan remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Calculations assume each public entity is contributing 50 percent of the Active Employee Only premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include these out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-3.055 High Deductible Health Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is deleting section (5); amending sections (1)–(3) and (6); adding section (7); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the high deductible benefit provisions and covered charges of the Missouri Consolidated Health Care Plan.*

(1) Deductible amount—Network: per individual each calendar year, one thousand two hundred dollars (\$1,200); family *[limit]* each calendar year, two thousand four hundred dollars (\$2,400). Non-network: per individual each calendar year, two thousand four hundred dollars (\$2,400); family *[limit]* each calendar year, four thousand eight hundred dollars (\$4,800).

(A) The family deductible *[must be met before claim payments begin, applicable when two (2) or more family members are covered]* applies when two (2) or more family members are covered. The family deductible must be met before claim payment begins for any covered member.

(B) During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and *[coinsurance]* out-of-pocket maximum. *[The newborn will not be subject to a separate deductible and coinsurance.]* The newborn will be subject to his/her *[own]* deductible and coinsurance after release from the hospital or if s/he is transferred to another hospital. **If the mother is not an Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.**

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims/— are paid at eighty percent (80%) until the out-of-pocket maximum is met.

(B) Non-network claims/— are paid at sixty percent (60%) until the out-of-pocket maximum is met.

(D) Claims shall be paid at eighty percent (80%) if required covered services are not available through network provider within one hundred (100) miles of the member's home. The *[participant]* member must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is for three (3) months. After three (3) months, the *[participant]* member must contact the claims administrator to reassess network availability.

(3) Out-of-pocket maximum—the maximum amount payable by the *[participant]* member before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.

(B) The family out-of-pocket maximum applies when two (2) or more family members are covered. The family out-of-pocket maximum must be met before claim payment begins for any covered member.

*[(A)](C)* Network out-of-pocket maximum for individual—two thousand four hundred dollars (\$2,400).

*[(B)](D)* Network out-of-pocket maximum for family—four thousand eight hundred dollars (\$4,800).

*[(C)](E)* Non-network out-of-pocket maximum for individual—four thousand eight hundred dollars (\$4,800).

*[(D)](F)* Non-network out-of-pocket maximum for family—nine thousand six hundred dollars (\$9,600).

*[(E)](G)* Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged: claims for services paid at one hundred percent (100%); charges above the *[U]sual, [C]ustomary, and [R]easonable (UCR)* limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

*[(5)]* Pharmacy benefits are subject to the High Deductible Health Plan (HDHP) deductible and coinsurance.]

*[(6)](5)* A member does not qualify for the HDHP if they are covered under or enrolled in any of the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only and dependent care section;

(D) Health reimbursement account (HRA); or

(E) The *[participant]* member has veteran's benefits that have been used within the past three (3) months.

*[(7)](6)* A member may qualify for this plan even if s/he is covered by any of the following:

(A) Drug discount card;

(B) Accident insurance;

(C) Disability insurance;

(D) Dental insurance;

(E) Vision insurance; or

(F) Long-term care insurance.

**(7) Usual, customary, and reasonable fee allowed—Non-network medical claims are processed at the eighty-fifth percentile of usual, customary, and reasonable fees as determined by the vendor.**

*AUTHORITY: section 103.059, RSMo 2000, and section 103.080.3, RSMo Supp. 2010. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions two thousand two hundred forty-four dollars (\$2,244) in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities two thousand two hundred forty-four dollars (\$2,244) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 3**

<b>Rule Number and Name:</b>	<b>22 CSR 10-3.055 High Deductible Health Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

<b>Affected Agency or Political Subdivision</b>	<b>Estimated Cost of Compliance in the Aggregate</b>
<b>Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003</b>	<b>\$ 2,244</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the Active Employee Only public entity premium for the HDHP for all public entity employees who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under the HDHP as of August 1, 2011;
- Calendar year 2012 membership in the HDHP Plan remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Calculations assume each public entity is contributing 50 percent of the premium;
- Actual claim costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.055 High Deductible Health Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>1 individual enrolled in the MCHCP Public Entity HDHP for CY 2012</b>	<b>Individuals enrolled in the MCHCP Public Entity HDHP for CY 2012</b>	<b>\$2,244</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the Active Employee Only public entity premium, plus 100 percent of the additional premium for other levels of coverage for the HDHP to all public entity employees who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under the HDHP as of August 1, 2011;
- Calendar year 2012 membership in the HDHP remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Calculations assume each public entity is contributing 50 percent of the Active Employee Only premium;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges.** The Missouri Consolidated Health Care Plan is amending sections (1)–(3); adding section (4); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the PPO 600 benefit provisions and covered charges for members of the Missouri Consolidated Health Care Plan.*

(1) Deductible amount—Network: per individual each calendar year, six hundred dollars (\$600); family *[limit]* each calendar year, one thousand two hundred dollars (\$1,200). Non-network: per individual each calendar year, one thousand two hundred dollars (\$1,200); family *[limit]* each calendar year, two thousand four hundred dollars (\$2,400).

(C) During a hospital admission for delivery, only the covered mother's claims will be subject to deductible and coinsurance. *[The newborn will not be subject to a separate deductible and coinsurance.]* The newborn will be subject to his/her *[own]* deductible and coinsurance after release from the hospital or if he/she is transferred to another hospital. **If the mother is not a Missouri Consolidated Health Care Plan (MCHCP) member, the newborn's claims will be subject to deductible and coinsurance during the hospital admission.**

(2) Coinsurance—coinsurance amounts apply after deductible has been met. Coinsurance is no longer applicable for the remainder of the calendar year once the out-of-pocket maximum is reached.

(A) Network claims~~[/—]~~ are paid at ninety percent (90%) until the out-of-pocket maximum is met.

(B) Non-network claims~~[/—]~~ are paid at seventy percent (70%) until the out-of-pocket maximum is met.

(D) Claims shall be paid at ninety percent (90%) if the subscriber requires covered services that are not available through a network provider within one hundred (100) miles of his/her home. The *[participant]* member must contact the claims administrator before the date of service in order to have a local provider approved. Such approval is for three (3) months. After three (3) months, the *[participant]* member must contact the claims administrator to reassess network availability.

(3) Out-of-pocket maximum—the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

(A) **Network and non-network out-of-pocket maximums are separate. Expenses cannot be shared or transferred between network and non-network benefits.**

(B) **The family out-of-pocket maximum is an aggregate of applicable charges received by all covered members of the plan. Any combination of covered family member out-of-pocket maximums may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.**

*[(A)](C)* Network out-of-pocket maximum for individual—one thousand five hundred dollars (\$1,500).

*[(B)](D)* Network out-of-pocket maximum for family—three thousand dollars (\$3,000).

*[(C)](E)* Non-network out-of-pocket maximum for individual—three thousand dollars (\$3,000).

*[(D)](F)* Non-network out-of-pocket maximum for family—six thousand dollars (\$6,000).

*[(E)](G)* Services that do not apply to the out-of-pocket maximum and for which applicable costs will continue to be charged include: claims for services paid at one hundred percent (100%); charges above the usual, customary, and reasonable (UCR) limit; the amount the member pays due to noncompliance; and charges above the maximum allowable amount for transplants performed by a non-network provider.

**(4) Usual, customary, and reasonable fee allowed—Non-network medical claims are processed at the eighty-fifth percentile of usual, customary, and reasonable fees as determined by the vendor.**

*[(4)](5)* Any claim must be submitted within twelve (12) months of claim being incurred. The plan reserves the right to deny claims not timely filed.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions \$1,544,241 in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities \$2,008,271 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Name:</b>	<b>22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003</b>	<b>\$ 1,544,241</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the Active Employee Only public entity premium for the PPO 600 Plan for all public entity employees who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under the PPO 600 Plan as of August 1, 2011;
- Calendar year 2012 membership in the PPO 600 Plan remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Calculations assume each public entity is contributing 50 percent of the Active Employee Only premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual claim costs will vary based upon actual utilization of services.



**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>527 individuals enrolled in the MCHCP Public Entity PPO 600 Plan for CY 2012</b>	<b>Individuals enrolled in the MCHCP Public Entity PPO 600 Plan for CY 2012</b>	<b>\$ 2,008,271</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the Active Employee Only public entity premium, plus 100 percent of the additional premium for other levels of coverage for the PPO 600 Plan to all public entity employees who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under the PPO 600 Plan as of August 1, 2011;
- Calendar year 2012 membership in the PPO 600 Plan remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Calculations assume each public entity is contributing 50 percent of the Active Employee Only premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED RESCISSION**

**22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges.** This rule established the policy of the board of trustees in regard to the medical plan benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded and readopted to include detailed language to clarify medical plan benefit provisions and covered charges.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Emergency rescission filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Rescinded: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED RULE**

**22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the Medical Plan Benefit Provisions and Covered Charges for participation in the Missouri Consolidated Health Care Plan.*

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.*

(1) Benefit Provisions Applicable to the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and High Deductible Health Plan (HDHP). Subject to the plan provisions, limitations, and enrollment of the employee, the benefits are payable for covered charges incurred by a member while covered under the plans, provided the deductible requirement, if any, is met.

(2) Covered Charges Applicable to the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP.

(A) Covered charges are only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a non-covered service. This includes covered services:

1. Prescribed by an appropriate health care provider for the therapeutic treatment of injury or sickness;

2. To the extent they do not exceed any limitation or exclusion; and

3. For not more than the usual, customary, and reasonable charge, as determined by the claims administrator for the services provided, will be considered covered charges.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, customary, and reasonable, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and

2. The usual, customary, and reasonable charges in the area in which services and/or supplies are provided.

(C) A physician visit to seek a second opinion is a covered service.

(D) Services in a Country Outside of the United States. Emergency room and urgent care medical services are covered at the network benefit. All other non-emergency services are covered at the non-network benefit.

(E) Medical plan benefits, limitations, and exclusions effective January 1, 2012, are incorporated by reference into this rule and are available to any interested person at the Missouri Consolidated Health Care Plan, 832 Weathered Rock Court, Jefferson City, MO 65101, or online at [www.mchcp.org](http://www.mchcp.org). This rule does not include any later amendments or additions.

(F) Plan benefits for the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP are as follows:

1. Allergy testing and immunotherapy. Allergy testing and allergy immunotherapy is covered for members with clinically significant allergic symptoms. No coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning;

2. Ambulance service. Ambulance transport services involve the use of specially designed and equipped vehicles to transport ill or injured individuals. Ambulance transportation by ground to the nearest appropriate facility is covered when medically necessary and other means of transportation would be contraindicated. This can include emergent and non-emergent, yet medically necessary situations. Ambulance transportation by air to the nearest appropriate facility is covered when medically necessary and only if the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Use of air ambulance or medical helicopter service from any country returning to the U.S. is excluded;

3. Applied behavior analysis for autism. For children younger than age nineteen (19), the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of observation, measurement, and functional analysis of the relationship between environment and behavior are covered with a forty thousand dollar (\$40,000) annual limit. The annual limit may be exceeded, upon prior authorization by the medical plan, if services beyond the annual limit are medically necessary;

4. Bariatric surgery. Open or laparoscopic Roux-en-Y gastric bypass (RYGB), open or laparoscopic sleeve gastrectomy (SG), open or laparoscopic biliopancreatic diversion (BPD) with or without duodenal switch (DS), or laparoscopic adjustable silicone gastric banding

(LASGB) are covered when specific health criteria are met;

5. Birth control devices and injections. Birth control is any method used to prevent pregnancy. Food and Drug Administration (FDA)-approved birth control devices and injections are covered when administered in a physician's office;

6. Cancer trials. Coverage for routine patient care costs incurred as the result of a Phase II, III, or IV clinical trial that is approved by an appropriate entity and is undertaken for the purposes of the prevention, early detection, or treatment of cancer. Coverage includes routine patient care costs incurred for drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's condition. Coverage includes reasonable and medically necessary services needed to administer the drug or use the device under evaluation in the clinical trial;

7. Cardiac rehabilitation. Coverage for an electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) as medically necessary when it is individually prescribed by a physician and a formal exercise stress test is completed following the event and prior to the initiation of the program. Up to thirty-six (36) visits are covered within a twelve (12)-week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

8. Chelation therapy. Chelation therapy agents covered for FDA-approved indication(s) and associated condition(s). Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit are explicitly excluded under MCHCP's benefit plan. Therefore, treatment of metal toxicity that occurs as a result of occupational exposure is not covered;

9. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered. Up to twenty-six (26) visits covered annually. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

10. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation is covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device.

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

11. Dental care/accidental injury. Treatment to reduce trauma and restorative services only when the result of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease. Oral surgery is covered when medically necessary as a direct result of injury, tumors, or cysts. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5), the severely disabled, or a person with a medical or behavioral condition that requires hospitalization. General anesthesia is covered when dental care is provided in a participating or non-participating hospital or surgical center;

12. Durable medical equipment (DME)/medically necessary disposable supplies. DME is covered when the equipment is ordered by a physician to treat an injury or sickness (illness). DME includes, but is not limited to, insulin pumps, oxygen, augmentative communication devices, and manual and powered mobility devices. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to, colostomy and ureterostomy bags and prescription compression stockings, are cov-

ered. Prescription compression stockings are limited to two (2) pairs or four (4) individual stockings per plan year. Non-reusable disposable supplies, including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinence pads, irrigating kits, pressure leotards, surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered. Repair and replacement of DME is covered when—

A. Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

B. Routine wear and tear of the equipment renders it non-functional and the member still requires the equipment; or

C. The physician provides documentation that the condition of the member changes or if growth-related;

13. Emergency room services. An emergency medical condition is defined as the manifestation of acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If admitted to hospital, may be required to transfer to network facility for maximum benefit;

14. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

15. Foot care (trimming of nails, corns, or calluses). Foot care services are covered when associated with systemic conditions that are significant enough to result in severe circulatory insufficiency and/or areas of desensitization in the lower extremities and service is provided by a qualified health provider. Foot care is considered routine in nature and not medically necessary in the absence of systemic disease that has resulted in severe circulatory insufficiency and/or areas of desensitization in the lower extremities;

16. Genetic counseling. The National Society of Genetic Counselors defines genetic counseling as: "The process of helping people understand and adapt to the medical, psychological, and familial implications of genetic contributions to disease." Pre-test and post-test genetic counseling with a physician or a licensed or certified genetic counselor covered as medically necessary for an individual recommended for covered heritable genetic testing;

17. Genetic testing. No coverage for testing based on family history alone. Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

A. The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

B. The result of the test will directly impact the treatment being delivered to the member;

C. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

D. After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

18. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

19. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars (\$200), and the lifetime maximum is three thousand two hundred dollars (\$3,200);

20. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars (\$1,000).

B. Programmable: two thousand dollars (\$2,000).

C. Digital: two thousand five hundred dollars (\$2,500).

D. Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars (\$3,500);

21. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by physician;

22. Home health care. Skilled home health care is covered for members who are homebound because of illness or injury (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent, or of short duration, or to receive medical care); services must be performed by a registered nurse or licensed practical (vocational) nurse, licensed therapist, or a registered dietitian;

23. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care which is directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week;

24. Hospital (includes inpatient, outpatient, and surgical centers). The following benefits are covered:

A. Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

B. Intensive care unit room and board;

C. Surgery, therapies, and ancillary services—

(I) Cornea transplant-travel and lodging are not covered for cornea transplant;

(II) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(III) Sterilization for the purpose of birth control is covered;

(IV) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(V) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19); and

(VI) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

D. Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(I) Member must be ill in more than one area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(II) The member's mental health disorder must be treatable in an inpatient facility;

(III) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region; and

(IV) The attending physician must be a psychiatrist. If the admitting physician is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board eligible or board certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of mental health disorders;

E. Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multi-disciplinary services not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment;

F. Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and

G. Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(I) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(II) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(III) A state-licensed psychologist;

(IV) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(V) Licensed professional counselor;

25. Lab, X-ray and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom, and to detect or monitor a condition;

26. Maternity coverage. Prenatal and postnatal care is covered. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two (2)-visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility;

27. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program when ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian), up to three (3) sessions annually with a registered dietitian, with physician order. The maximum may be exceeded for an additional three (3) sessions, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program because they are not considered to be medically necessary. Conditions for which nutritional evaluation and counseling are not considered to

be medically necessary include, but are not limited to, the following:

- A. Attention-deficit/hyperactivity disorder (ADHD);
- B. Chronic fatigue syndrome (CFS);
- C. Idiopathic environmental intolerance (IEI); or
- D. Asthma;

28. Nutritional therapy. Nutritional therapy is covered when it is the sole source of nutrition or a significant percentage of the daily caloric intake; is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder; is prescribed by a physician; is necessary to sustain life or health; and requires ongoing evaluation and management by a licensed healthcare provider;

29. Office visit. Member encounter with a health care or mental health care/chemical dependency provider in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan being provided, including non-specialty infusions and injections. Specialty injections NEUPOGEN® (Filgrastim) and Neulasta® (Pegfilgrastim) are covered under the medical plan when the treating physician deems it medically necessary to be administered in the physician's office rather than as a self-injectable;

30. Orthotics. Therapeutic shoes, inserts, and/or modifications to therapeutic shoes; thoracic-lumbar-sacral orthosis, lumbar orthosis, or lumbar-sacral orthosis; helmets—covered when cranial protection is required due to a documented medical condition that makes the recipient susceptible to injury during activities of daily living; and cranial orthosis for plagiocephaly, cervical orthosis, hip orthosis, knee orthosis, and ankle-foot/knee-ankle-foot orthoses (AFO) are covered;

31. Physical, speech, and occupational therapy and rehabilitation services (outpatient). Up to sixty (60) combined visits allowed per incident if showing significant improvement. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary;

32. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Annual physical exams (well man, woman, and child) and routine lab and X-ray services ordered as part of the annual exam. One exam (1) per calendar year is covered. For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

F. Cancer screenings—

- (I) Mammograms—one exam per year, no age limit;
- (II) Pap smears—one per year, no age limit;
- (III) Prostate—one per year, no age limit; and
- (IV) Colorectal screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive regardless of diagnosis. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Flu vaccination (influenza). The seasonal flu vaccine is covered under the preventive care benefit. When shot is obtained out-of-network, member must submit a receipt and a Non-Network Flu Shot Reimbursement form to medical plan to receive up to twenty-five dollars (\$25). Multiple vaccinations covered if recommended by the Missouri Department of Health and Senior Services or by the Centers for Disease Control and Prevention.

(I) Standard or preservative-free injectable influenza vaccine is a medically necessary preventive service for members when

influenza immunization is recommended by the member's doctor.

(II) Intradermal influenza vaccine is a medically necessary preventive service for members eighteen (18) to sixty-four (64) years of age when influenza immunization is recommended by the member's doctor.

(III) Intranasally administered influenza vaccine is a medically necessary alternative to injectable influenza vaccine for immunocompetent healthy persons two (2) to forty-nine (49) years of age when influenza immunization is recommended by the member's doctor;

33. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement not covered unless due to normal wear and tear, if there is a change in medical condition, or if growth-related.

34. Pulmonary rehabilitation. Up to thirty-six (36) visits within a twelve (12)-week period per incident. The maximum may be exceeded, upon prior authorization by the medical plan, if services beyond the maximum limit are medically necessary. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and postoperative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) and/or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake ( $\text{VO}_2\text{max}$ ) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METs); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

35. Skilled nursing facility. Benefits are limited to one hundred twenty (120) days per calendar year;

36. Stimulators (for bone growth). Implantable bone growth stimulators covered as an outpatient surgery, nonimplantable bone growth stimulator covered under durable medical equipment.

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)). Medically necessary DME to accelerate healing of fresh fractures, fusions, or delayed unions.

B. Electrical stimulation. Direct current electrical bone-growth stimulator medically necessary for delayed unions of fractures or failed arthrodesis, non-unions, failed fusions, and congenital pseudarthrosis and members who are at high risk for spinal fusion failure;

37. Transplants. When neither experimental nor investigational and medically necessary: bone marrow, kidney, liver, heart, lung, pancreas, intestinal, or any combination are covered under the transplant

benefits. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements. Travel, if approved, is limited to ten thousand dollars (\$10,000) maximum per transplant.

A. Network. Includes travel and lodging allowance for recipient and his/her immediate family travel companion (younger than nineteen (19), both parents) if transplant facility is more than one hundred (100) miles from residence.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to [www.gsa.gov](http://www.gsa.gov) for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Transplant benefits at a non-network facility. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals not covered. Non-network facility charges and payments for transplants are limited to the following maximum only:

(I) Allogenic bone marrow—one hundred forty three thousand dollars (\$143,000);

(II) Autologous bone marrow—one hundred twenty-one thousand dollars (\$121,000);

(III) Heart—one hundred twenty-eight thousand dollars (\$128,000);

(IV) Heart and lung—one hundred thirty-three thousand dollars (\$133,000);

(V) Lung—one hundred fifty-one thousand dollars (\$151,000);

(VI) Kidney—Fifty-four thousand dollars (\$54,000);

(VII) Kidney and pancreas—ninety-seven thousand dollars (\$97,000); and

(VIII) Liver—one hundred fifty-three thousand dollars (\$153,000);

38. Urgent care. Services to prevent rapid and/or serious deterioration in a member's health as a result of injury or illness. Urgent care serves as an alternative to the hospital emergency room and the personal physician when a timely appointment is not available. Urgent care is appropriate for injuries too severe to be seen in a primary care physician's office but not severe enough to require treatment in a hospital emergency department; and

39. Vision. Routine exam (including refractions). One (1) per covered person per calendar year.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Emergency rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Rescinded and readopted: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rule will cost state agencies or political subdivisions \$3,593,202 in the aggregate.*

*PRIVATE COST: This proposed rule will cost private entities \$4,895,873 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 3**

<b>Rule Number and Name:</b>	<b>22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003</b>	<b>\$3,593,202</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the Active Employee Only public entity premium for all public entity employees who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under the all public entity plans as of August 1, 2011;
- Calendar year 2012 membership in the public entity plans remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Calculations assume each public entity is contributing 50 percent of the Active Employee Only premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual claim costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>1,403 individuals enrolled in MCHCP public entity plans for CY 2012</b>	<b>Individuals enrolled in MCHCP public entity plans for CY 2012</b>	<b>\$4,895,873</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the Active Employee Only public entity premium, plus 100 percent of the additional premium for other levels of coverage for all public entity employees who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under all public entity plans as of August 1, 2011;
- Calendar year 2012 membership in the all public entity plans remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Calculations assume each public entity is contributing 50 percent of the Active Employee Only premium;
- Calculations include pharmacy costs as outlined in 22 CSR 10-3.090;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.



**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP Limitations.** The Missouri Consolidated Health Care Plan is deleting sections (4), (9), (13), (18), (21), (27), (31), (43), (48)–(50), (52), (55), (57)–(59), (62)–(64), and (66)–(68); amending sections (5), (19), (26), (35), (38), (39), (44), (47), (61), and (65); adding sections (8) and (45); and renumbering as necessary.

*PURPOSE: This amendment changes the limitations and exclusions of the Missouri Consolidated Health Care Plan PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP.*

*[(4)] Allergy services—no coverage for non-physician allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning.]*

*[(5)](4) Alternative therapies—including, but not limited to, acupuncture, acupressure, homeopathy, hypnosis, massage therapy, reflexology, and biofeedback[, and other forms of alternative therapy with the exception of aquatic therapy performed by a physical therapist].*

*[(6)](5) Assistant surgeon services—not covered unless determined to meet the clinical eligibility for coverage under the plan.*

*[(7)](6) Athletic trainer services—services by a licensed athletic trainer not covered.*

*[(8)](7) Autopsy.*

*[(9) Bariatric procedures—not covered except for members who have undergone bariatric procedures before December 31, 2010, that were approved by the medical plan will receive follow-up care until December 31, 2011. Revisions and corrections of bariatric procedures are covered only when the revision is used to treat life-threatening complications (e.g., wound infection, abscess, dehiscence, gastric leaking, and embolism).]*

**(8) Birthing center.**

*[(10)](9) Blood donor expenses—not covered.*

*[(11)](10) Blood pressure cuffs/monitors—not covered.*

*[(12)](11) Blood storage—not covered, including whole blood, blood plasma, and blood products.*

*[(13) Breast augmentation mammoplasty—not covered unless associated with breast surgery following a medically necessary mastectomy incurred secondary to active disease.]*

*[(14)](12) Care received without charge.*

*[(15)](13) Charges resulting from the failure to appropriately cancel a scheduled appointment.*

*[(16)](14) Childbirth classes.*

*[(17)](15) Comfort and convenience items.*

*[(18) Cosmetic, plastic, reconstructive, or restorative surgery—unless medically necessary to repair a functional disorder caused by disease or injury, or congenital defect or abnormality (for a participant under the age of nineteen (19)), or to restore symmetry following a mastectomy.]*

*[(19)](16) Custodial or domiciliary care—includes services and supplies that assist members in the activities of daily living [like] such as walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet; preparation of special diets; supervision of medication that is usually self-administered; or other services that can be provided by persons without the training of a health care provider.*

*[(20)](17) Dental—treatment must be initiated within sixty (60) days of accident. Limited to treatment of accidental injury to sound, natural teeth and tissue that are viable, functional, and free of disease. Oral surgery is covered only when medically necessary as a direct result from injury, tumors, or cysts. Dental care, including oral surgery, as a result of poor dental hygiene is not covered. Extractions of bony or partial bony impactions are excluded.*

*[(21) Durable medical equipment and disposable supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose. Over-the-counter medications and supplies. Prescription compression stockings are limited to two (2) pairs of four (4) individual stockings per plan year.]*

*[(22)](18) Educational or psychological testing—not covered unless part of a treatment program for covered services.*

*[(23)](19) Examinations requested by a third party.*

*[(24)](20) Excessive charges—any otherwise eligible expenses that exceed the maximum allowance or benefit limit.*

*[(25)](21) Exercise equipment.*

*[(26)](22) Experimental services or investigational services—experimental or investigational services, procedures, supplies, or drugs as determined by the claims administrator are not covered[, except clinical trials for cancer treatment as specified by law].*

*[(27) Eye glasses and contact lenses—charges incurred in connection with the fitting of eye glasses or contact lenses except for initial placement immediately following cataract surgery.]*

*[(28)](23) Eye services—health services and associated expenses for orthoptics, eye exercises, radial keratotomy, LASIK, and other refractive eye surgery.*

*[(29)](24) Services obtained at a government facility—not covered if care is provided without charge.*

*[(30)](25) Gender reassignment—health services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment.*

*[(31) Hair analysis, wigs, and hair transplants—services related to the analysis of hair unless used as a diagnostic tool to determine poisoning. Also, hairstyling wigs, hairpieces, and hair prostheses, including those ordered by a participating provider, are not covered. Such items and services are not*

*covered except for members ages eighteen (18) and under with alopecia as specified by law. Subject to two hundred dollar (\$200) annual maximum and three thousand two hundred dollar (\$3,200) lifetime maximum.]*

[(32)](26) Health and athletic club membership—including costs of enrollment.

[(33)](27) Home births.

[(34)](28) Immunizations requested by third party or for travel.

[(35)](29) Infertility treatment. **Services are covered to diagnose the condition.**

[(36)](30) Level of care, if greater than is needed for the treatment of the illness or injury.

[(37)](31) Long-term care.

[(38)](32) Medical care and supplies—not **covered** to the extent that they are payable under—

(A) A plan or program operated by a national government or one (1) of its agencies; or

(B) Any state's cash sickness or similar law, including any group insurance policy approved under such law.

[(39)](33) Medical service performed by a family member—including a person who ordinarily resides in the subscriber's household or is related to the *[participant]* **member**, such as a spouse, parent, child, sibling, or brother/sister-in-law.

[(40)](34) Military service connected injury or illness—including expenses relating to Veterans Affairs or a military hospital.

[(41)](35) Never events—twenty-eight (28) occurrences on a list compiled by the National Quality Forum of inexcusable outcomes in a health care setting. They are defined as adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.

[(42)](36) Nocturnal enuresis alarm.

[(43)] *Non-network providers—subject to higher deductible and non-network coinsurance.*

[(44)](37) Not medically necessary services[—*with the exception of preventive services*].

[(45)](38) Orthognathic surgery.

[(46)](39) Orthoptics.

[(47)](40) Other charges—no coverage for charges that would not be incurred if the subscriber was not covered. Charges for which the subscriber or his/her dependents are not legally obligated to pay including, but not limited to, any portion of any charges that are discounted. Charges made in the subscriber's name but which are actually due to the injury or illness of a different person not covered by the plan. Miscellaneous service charges—telephone consultations, charges for failure to keep scheduled appointment *[(unless the scheduled appointment was for a mental health service)]*, or any late payment charge.

[(48)] *Outpatient birthing centers.*

[(49)] *Over-the-counter medications—except for insulin and drugs recommended by the U.S. Preventive Services Task*

*Force (Categories A and B) as prescribed by a physician and included on the formulary through the pharmacy benefit.*

[(50)] *Over-the-counter supplies—non-reusable disposable supplies including, but not limited to, bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose.]*

[(51)](41) Physical fitness.

[(52)] *Physical, speech, and occupational therapy—health services and associated expenses for development delay. Treatment for disorders relating to delays in learning, motor skills, and communications.]*

[(53)](42) Private duty nursing.

[(54)](43) Prognathic and maxillofacial surgery.

[(55)] *Prosthetic repair or replacement—not covered unless due to normal wear and tear, if there is a change in medical condition, if growth related, or medically necessary.]*

[(56)](44) Self-inflicted injuries—not covered unless related to a mental diagnosis.

**(45) Sex therapy.**

[(57)] *Services not specifically included as benefits.*

[(58)] *Services rendered after termination of coverage—those services otherwise covered under the agreement, but rendered after the date coverage under the agreement terminates, including services for medical conditions arising prior to the date individual coverage under the agreement terminates.*

[(59)] *Stimulators (for bone growth)—not covered unless prior authorized by claims administrator and clinical eligibility is met.]*

[(60)](46) Surrogacy—pregnancy coverage is limited to plan member.

[(61)] *Temporo-Mandibular* **(47) Temporomandibular Joint Syndrome (TMJ). Services are covered to diagnose the condition.**

[(62)] *Tobacco cessation—patches and gum are not covered.*

[(63)] *Transplant benefits at a non-network facility. Non-network facility charges and payments for transplants are limited to the following maximum only:*

(A) *Allogenic Bone Marrow—\$143,000;*

(B) *Autologous Bone Marrow—\$121,000;*

(C) *Heart—\$128,000;*

(D) *Heart and Lung—\$133,000;*

(E) *Lung—\$151,000;*

(F) *Kidney—\$54,000;*

(G) *Kidney and Pancreas—\$97,000; and*

(H) *Liver—\$153,000.*

[(64)] *Transplants—travel expense—requires authorization from medical plan. Limited to ten thousand dollar (\$10,000) maximum per transplant when accessing network services. Travel expenses include travel and lodging allowance for recipient and his/her immediate family travel companion. When a participant is younger than nineteen (19) years of*

*age, travel expenses are covered for both parents. Transplant facility must be more than one hundred (100) miles from the recipient's residence. Meals are not covered.]*

*[(65)](48) Travel expenses—not covered except for transplants in a **transplant** network facility.*

*[(66) Trimming of nails, corns, or calluses—not covered except for persons being treated for diabetes, peripheral vascular disease, or blindness.*

*(67) Usual, Customary, and Reasonable (UCR)—charges exceeding UCR are not covered, as applicable to the non-network benefit.*

*(68) Vitamins and nutrients—limited to prenatal agents for pregnancy, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents through the pharmacy benefit.]*

*[(69)](49) Workers' compensation—charges for services or supplies for an illness or injury eligible for, or covered by, any federal, state, or local government Workers' Compensation Act, occupational disease law, or other similar legislation.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions twenty-three thousand one hundred ninety-three dollars (\$23,193) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Name:</b>	<b>22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan and HDHP Limitations</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

<b>Affected Agency or Political Subdivision</b>	<b>Estimated Cost of Compliance in the Aggregate</b>
<b>Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003</b>	<b>\$23,193</b>

**III. WORKSHEET**

Estimated cost is the annual cost of MCHCP providing coverage for bariatric surgery for calendar year 2012.

**IV. ASSUMPTIONS**

- One procedure per year;
- Projected cost of procedure is \$23,193

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-3.070 Coordination of Benefits.** The Missouri Consolidated Health Care Plan is amending sections (2) and (3).

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the coordination of benefits (COB) in the Missouri Consolidated Health Care Plan.*

(2) Definitions. The following words and terms, when used in this rule, shall have the following meanings unless the context clearly indicates otherwise:

(A) Allowable expenses.

1. Allowable expense means the necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

2. Notwithstanding this definition, items of expense under coverage/s/, such as dental care, vision care, prescription drug, or hearing-aid programs, may be excluded from the definition of allowable expense. A plan which provides benefits only for any of these items of expense may limit its definition of allowable expenses to like items of expense.

3. When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

4. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under this definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

5. When COB is restricted in its use to specific coverage in a contract (for example, major medical or dental), the definition of allowable expense must include the corresponding expenses or services to which COB applies.

6. When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of this reduction will not be considered an allowable expense. Examples of these provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

A. Only benefit reductions based upon provisions similar in purpose to those described previously and which are contained in the primary plan may be excluded from allowable expenses.

B. This provision shall not be used to refuse to pay benefits because a health maintenance organization (HMO) member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its contract, is not obligated to pay for providing those services;

(3) Order of Benefit Determination Rules.

(B) Rules. MCHCP determines its order of benefits using the first of the following rules which applies:

**1. Active/inactive employee. The benefits of the plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of the plan which covers that person as a laid off or retired employee (or as that employee's dependent);**

**[1.]2. Nondependent/dependent. The benefits of the plan which covers the person as an employer or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; [except that—if the person is also a Medicare beneficiary, and as a result of the rule established**

**by the Title XVIII of the Social Security Act and implementing regulations, Medicare is—**

**A. Secondary to the plan covering the person as a dependent;**

**B. Primary to the plan covering the person as other than a dependent (for example, a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent;**

**C. Primary if the person is eligible for Medicare due to disability; and**

**D. Primary after the first thirty (30) months if the person is eligible for Medicare due to end stage renal disease;]**

**3. Medicare.**

**A. If a member is an active employee and has Medicare, MCHCP is the primary plan for the active employee and his/her dependents. Medicare is the secondary plan except for members with end stage renal disease (ESRD) as defined in subparagraph (3)(B)3.C.**

**B. If a member is a retiree and has Medicare, Medicare is the primary plan for the retiree and his/her Medicare-eligible dependents. MCHCP is the secondary plan.**

**C. If a member or his/her dependents are eligible for Medicare solely because of ESRD, the member's MCHCP plan is primary to Medicare during the first thirty (30) months of Medicare eligibility for home peritoneal dialysis or home hemodialysis and thirty-three (33) months for in-center dialysis. After the thirty (30) or thirty-three (33) months, Medicare becomes primary, and claims are submitted first to Medicare, then to MCHCP for secondary coverage. The member is responsible for notifying MCHCP of his/her Medicare status;**

**[2.]4. Dependent child/parents not separated or divorced. When MCHCP and another plan cover the same child as a dependent of different persons, called parents—**

**A. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but**

**B. If both parents have the same birthday, the benefits of the plan which covered one (1) parent longer are determined before those of the plans which covered the other parent for a shorter period of time;**

**[3.]5. Dependent child/separated or divorced, or never married. If two (2) or more plans cover a person as a dependent child of divorced, [or] separated, or never married parents, benefits for the child are determined in this order—**

**A. First, the plan of the parent with custody of the child;**

**B. Then, the plan of the spouse of the parent with the custody of the child;**

**C. Then, the plan of the parent not having custody of the child; and**

**D. Finally, the plan of the spouse of the parent not having custody of the child. However, if the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the plan of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge;**

**[4.]6. Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in paragraph (3)(B)2.4.;**

**[5.]7. Dependent child/parents both parents covered by MCHCP. If both parents are covered by MCHCP and both parents cover the child as a dependent, MCHCP will not coordinate benefits**

with itself; *[and]*

**8. The plan that covers the member as a spouse is primary over the plan that covers the member as a dependent child; and**

*[6.]9.* Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the plan which covered a person longer are determined before those of the plan which covered that person for the shorter term.

*AUTHORITY: sections 103.059 and 103.089, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. Rescinded and readopted: Filed July 1, 2010, effective Dec. 30, 2010. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED AMENDMENT**

**22 CSR 10-3.075 Review and Appeals Procedure.** The Missouri Consolidated Health Care Plan is amending sections (1)–(5); adding section (1); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to review and appeals procedures for participation in, and coverage of services under, the Missouri Consolidated Health Care Plan.*

**(1) General Provision. The board of trustees has the right to suspend, revise, or remove eligibility and benefit requirements in the case of a disaster or emergency situation.**

*[(1)](2) Claims Submissions and Initial Benefit Determinations.*

(A) Members shall use the claims and administration procedures established by the vendor administering the particular service for which coverage, authorization, or payment is sought.

(B) Medical and pharmacy service claims are divided into three (3) types: pre-service, post-service, and concurrent claims.

1. Pre-service claims are requests for approval that the plan or vendor requires a member to obtain before getting medical care or filling a prescription, such as prior authorization or a decision whether a treatment, procedure, or medication is medically necessary.

A. Pre-service claims must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than fifteen (15) days from the date the vendor receives the claim. The vendor may extend the time period up to an additional fifteen (15) days if, for reasons beyond the vendor's control, the decision cannot be made within the first fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional

information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

B. Urgent care claims are a special type of pre-service claim that require a quicker decision because waiting the standard time could seriously jeopardize the member's life, health, or ability to regain maximum function. A request for an urgent care claim may be submitted verbally or in writing and will be decided within seventy-two (72) hours. Written confirmation of the decision will be sent by the vendor as soon as possible thereafter.

2. Post-service claims are all other claims for services including claims after medical or pharmacy services have been provided, such as requests for reimbursement or payment of the costs for the services provided.

A. Post-service claims must be decided within a reasonable period of time, but not later than thirty (30) days after the vendor receives the claim. If, because of reasons beyond the vendor's control, more time is needed to review the claim, the vendor may extend the time period up to an additional fifteen (15) days. The vendor must notify the member prior to the expiration of the first fifteen (15)-day period, explain the reason for the delay, and request any additional information. If more information is requested, the member has at least forty-five (45) days to provide the information to the vendor. The vendor then must decide the claim no later than fifteen (15) days after the additional information is supplied or after the period of time allowed to supply it ends, whichever is first.

3. Concurrent claims are claims related to an ongoing course of previously[-] approved treatment. If the plan or vendor has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment will be treated as a benefit denial. The plan or vendor will notify a member in writing prior to reducing or ending a previously[-] approved course of treatment in sufficient time to allow the member or the member's provider to appeal and obtain a determination before the benefit is reduced or terminated.

(C) Claims incurred should be furnished to the vendor by the provider or the member as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the vendor before they are paid.

(D) If a member, or a provider, or authorized representative on behalf of a member, submits a request for coverage or a claim for services that is denied in whole or in part, the member will receive an initial denial notice within the time frames described in this rule that will include the following information:

1. The reasons for the denial;

2. Reference to the plan provision, regulation, statute, clinical criteria, or guideline on which the denial was based, with information as to how the member can obtain a copy of the provision, regulation, statute, clinical criteria, or guideline free of charge;

3. A description of any documentation or information that is necessary for the member to provide if documentation or information is missing and an explanation as to why the documentation or information is needed, if applicable; and

4. Information as to steps the member can take to submit an appeal of the denial.

*[(2)](3) General Appeal Provisions.*

(A) All individuals seeking review or appeal of a decision of the plan, plan administrator, claims administrator, or any vendor shall follow the procedures applicable to the type of decision appealed as set forth in this rule.

(B) All appeals must be submitted in writing to the appropriate reviewer as established in this rule by the member, the individual seeking review, or his/her authorized representative.

(C) Unless specifically provided otherwise in this rule, all appeals

to the plan, plan administrator, claims administrator, or applicable vendor must be made, initiated in writing, within one hundred eighty (180) days of receiving the denial or notice which gave *[rights]* rise to the appeal.

**[(3)](4) Appeal Process for Medical and Pharmacy Determinations.**

(A) Definitions. Notwithstanding any other rule in this chapter to the contrary, for purposes of a member's right to appeal any adverse benefit determination made by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor, relating to the provision of health care benefits, other than those provided in connection with the plan's dental or vision benefit offering, the following definitions apply.

1. Adverse benefit determination. An adverse benefit determination means any of the following:

A. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the plan;

B. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

C. Any rescission of coverage *[once]* after an individual has been covered under the plan.

2. Appeal (or internal appeal). An appeal or internal appeal means review by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor of an adverse benefit determination.

3. Claimant. Claimant means an individual who makes a claim under this subsection. For purposes of this subsection, references to claimant include a claimant's authorized representative.

4. External review. External review means a review of an adverse benefit determination (including a final internal adverse benefit determination) by the Missouri Department of Insurance, Financial Institutions and Professional Registration, Division of Consumer Affairs (DIFP) regarding covered medical *[and pharmacy]* benefits administered by *[plan vendors, UMR, Mercy Health Plans, or Express Scripts Inc.,]* **Coventry Health Care** in accordance with state law and regulations promulgated by DIFP *[and made applicable to the plan by agreement and between the plan and DIFP pursuant to Technical Guidance from the U.S. Department of Health and Human Services dated September 23, 2010].* **The United States Department of Health and Human Services (HHS) conducts external reviews for adverse benefit determinations regarding medical and pharmacy benefits administered by UMR and Express Scripts Inc. that involve medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational) and a rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time).**

5. Final internal adverse benefit determination. A final internal adverse benefit determination means an adverse benefit determination that has been upheld by the plan, the plan administrator, a claims administrator, or a medical or pharmacy benefit vendor at the completion of the internal appeals process under this subsection, or an adverse benefit determination with respect to which the internal appeals process has been deemed exhausted by application of applicable state or federal law.

6. Final external review decision. A final external review decision means a determination rendered under the *[DIFP]* external review process at the conclusion of an external review.

7. Rescission. A rescission means a termination or discontinu-

ance of medical or pharmacy coverage that has retroactive effect except that a termination or discontinuance of coverage is not a rescission if—

A. The termination or discontinuance of coverage has only a prospective effect;

B. The termination or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

C. The termination or discontinuance of coverage is effective retroactively at the request of the member in accordance with applicable provisions of this chapter regarding voluntary cancellation of coverage.

**(B) Internal Appeals.**

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual's coverage under the plan based on a determination of the individual's eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review *[by DIFP]* **except as specifically provided in 22 CSR 10-32.075(4)(A)4.**

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will

be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor who will have someone review the appeal who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First level appeals must be submitted in writing to—

UMR Claims Appeal Unit  
PO Box 30546  
Salt Lake City, UT 84130-0546

(b) Second level appeals must be sent in writing to—

UMR Claims Appeal Unit  
PO Box 8086  
Wausau, WI 54402-8086

(c) Expedited appeals must be communicated by calling UMR telephone 1-866-868-7758 or by submitting a written fax to 1-866-912-8464, Attention: Appeals Unit.

(VI) For members with medical coverage through *[Mercy Health Plans] Coventry Health Care—*

(a) First and second level appeals must be submitted in writing to—

*[Mercy Health Plans  
Attn: Corporate Appeals  
14528 S. Outer 40 Road, Suite 300  
Chesterfield, MO 63017]  
Coventry Health Care  
Attn: Appeals Department  
550 Maryville Centre, Ste. 300  
St. Louis, MO 63141*

(b) Expedited appeals must be communicated by calling *[Mercy Health Plans] Coventry Health Care* telephone *[1-800-830-1918, ext. 2394] 1-314-214-2394* or by submitting a written fax to 1-314-214-3233, Attention: Corporate Appeals.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member claimant attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the claimant believes the claim should be paid, and any other written documentation to support the claimant's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts  
*[Clinical Appeals—MH3  
6625 West 78th Street, BLO390]  
Attn: Pharmacy Appeals—MH3  
Mail Route 0390*

**6625 W. 78th St.**

Bloomington, MN 55439  
or by fax to 1-877-852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

**(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.**

**(II) The claimant can submit an external review request in writing to—**

**Office of Consumer Information and Oversight  
Department of Health and Human Services  
PO Box 791  
Washington DC 20044  
or by fax to 1-202-606-0036  
or by email to [disputedclaim@opm.gov](mailto:disputedclaim@opm.gov)**

**(III) The claimant may call the toll-free number 1-877-549-8152 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.**

**(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.**

**(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.**

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

**[(4)](5) Except as otherwise expressly provided in this rule, appeals of adverse determinations made by MCHCP may be appealed to the board by fax or letter to the following address:**

Attn: Appeal  
Board of Trustees  
Missouri Consolidated Health Care Plan  
PO Box 104355  
Jefferson City, MO 65110

**[(5)](6) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines.**

(A) Newborns—If a member currently has coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within three (3) months of the child's date



of birth.

(B) Agency error—MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office, *[the]* MCHCP, or plan offered by MCHCP that was no fault of the member.

(C) Any member wishing to change his/her plan selection made during the annual open enrollment period must request to do so in writing to the board of trustees within thirty-one (31) calendar days of the beginning of the new plan year. **Plan changes are effective February 1. If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

(D) Non-payment—MCHCP may allow one (1) reinstatement for terminations due to non-payment (per lifetime of account).

(E) Reinstatement before termination—MCHCP may reinstate coverage if request is received prior to end of current coverage.

(F) Termination dental and/or vision coverage—MCHCP may terminate dental and/or vision coverage if request is received prior to February 1 and if no claims have been made/paid for January. **If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, termination may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

(G) Proof of eligibility—MCHCP may approve late receipt of proof-of-eligibility documentation if MCHCP can verify that it took an unreasonable amount of time for the public entity (county or state) to provide subscriber with requested documentation.

(H) Change in medical plan selection—MCHCP may approve change of medical plans prospectively if request is received within the first thirty (30) days of the start of coverage. **If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

(I) Loss of coverage notice—MCHCP may approve late request to enroll due to late notice of loss of coverage from previous carrier if request is timely from date of late notice.

(J) *[Wellness Program]* **Lifestyle Ladder** participation—MCHCP may deny all appeals regarding continuation of participation in the *[Wellness]* **Lifestyle Ladder** Program due to failure of member's participation.

(K) Proof of open enrollment confirmation—MCHCP may approve appeals if subscriber is able to provide a confirmation sheet from open enrollment. However, such administrative appeals must be received by MCHCP on or before the last day of February.

(L) Substantiating evidence—MCHCP may approve appeals, other than those relating to non-payment, if subscriber is able to provide substantiating evidence that requisite information was sent during eligibility period.

(M) New employee changes—MCHCP may approve plan changes retrospectively for new employees within thirty (30) days of election of coverage if no claims have been filed with the previous carrier. **If a subscriber has his/her premium collected pre-tax by qualified payroll deduction through a cafeteria plan, changes may be approved if the reason given is allowed by the Missouri State Employees' Cafeteria Plan.**

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expired June 29, 2005. Original rule filed Dec. 20, 2004, effective June 30, 2005. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

### PROPOSED AMENDMENT

**22 CSR 10-3.090 Pharmacy Benefit Summary.** The Missouri Consolidated Health Care Plan is deleting sections (2), (4), and (8); amending the purpose and sections (1), (5), and (7); adding sections (6)–(8); and renumbering as necessary.

*PURPOSE: This amendment changes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for the PPO 600 Plan, PPO 1000 Plan, PPO 2000 Plan, and HDHP with HSA of the Missouri Consolidated Health Care Plan.*

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the Pharmacy Benefit Summary for the PPO 600 Plan, PPO 1000 Plan, [and] PPO 2000 Plan, and HDHP with HSA of the Missouri Consolidated Health Care Plan.*

(1) The pharmacy benefit provides coverage for prescription drugs. *[listed on the formulary, as described in the following:]* **Vitamins and nutrients coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a physician.**

(A) *[Medications]* **PPO 600, PPO 1000, and PPO 2000 Prescription Drug Coverage.**

1. Retail—Network:

A. Generic: Eight-dollar (\$8) copayment for up to a thirty (30)-day supply for a generic drug on the formulary; **formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%);**

B. Brand: Thirty-five-dollar (\$35) copayment for up to a thirty (30)-day supply for a brand drug on the formulary; **formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%);**

C. Non-formulary: **One hundred-dollar (\$100) copayment for up to a thirty (30)-day supply for a drug not on the formulary;**

*[C./D. [Mail order] Home delivery program—*

*(I) [Prescriptions may be filled through the mail order program and the member will receive up to a ninety (90)-day supply for a twenty-dollar (\$20) copayment for a generic drug on the formulary or a eighty-seven-dollar-and-fifty-cent (\$87.50) copayment for a brand drug on the formulary.] Maintenance prescriptions may be filled through the home delivery program. Some medications may not apply for the program because they require prior authorization or quantity level limits.*

(a) Generic: Twenty-dollar (\$20) copayment for up to a ninety (90)-day supply for a generic drug on the formulary.

(b) Brand: Eighty-seven-dollar and fifty-cent (\$87.50) copayment for up to a ninety (90)-day supply for a brand drug on the formulary.

(c) Non-formulary: Two hundred fifty-dollar (\$250)

copayment for up to a ninety (90)-day supply for a drug not on the formulary; and

(II) Specialty drugs covered only through network *[mail order]* home delivery for up to thirty (30) days. *[Copayments—]* The first specialty prescription order may be filled through a retail pharmacy.

(a) Generic: */e/*Eight dollars (\$8) for generic drug on the formulary list; *and/*.

(b) Brand: */t/*Thirty-five dollars (\$35) for brand drug on the formulary.

(c) Non-formulary: One hundred-dollar (\$100) copayment for a drug not on the formulary; and

E. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

F. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment;

G. If the physician allows for generic substitution and the member chooses a brand name drug, the member is responsible for the generic copayment and the cost difference between the brand name and generic drug; and

H. Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary through the pharmacy benefit.

2. *[Non-network pharmacies—]* Retail—Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. *[S/he will be reimbursed the amount that would have been allowed at an in-network pharmacy, less any applicable copayment or coinsurance. All such claims must be filed within twelve (12) months of the incurred expense.]* The pharmacy vendor will reimburse the cost of the drug based on the network discounted amount, less the applicable copayment.

A. Generic: Eight-dollar (\$8) copayment for up to a thirty (30)-day supply for a generic drug on the formulary.

B. Brand: Thirty-five-dollar (\$35) copayment for up to a thirty (30)-day supply for a brand drug on the formulary.

C. Non-formulary: One hundred-dollar (\$100) copayment for up to a thirty (30)-day supply for a drug not on the formulary.

*[3. Retail prescription drugs—Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.]*

(B) High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Prescription Drug Coverage.

#### 1. Retail—Network:

A. Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary; tobacco cessation prescriptions covered at 100%;

B. Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary; tobacco cessation prescriptions covered at 100%;

C. Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary;

#### D. Home delivery program.

(I) Maintenance prescriptions may be filled through the home delivery program. Some medications may not apply for the program because they require prior authorization or quantity level limits.

(a) Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

(c) Non-formulary: Thirty percent (30%) coinsurance

after deductible for a drug not on the formulary.

(II) Specialty drugs covered only through network home delivery for up to thirty (30) days.

(a) Generic: Twenty percent (20%) coinsurance after deductible for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary; and

(c) Non-formulary: Thirty percent (30%) coinsurance after deductible for a drug not on the formulary; and

E. Over-the-counter medications covered as recommended by the U.S. Preventive Services Task Force (categories A and B) at one hundred percent (100%) as prescribed by a physician and included on the formulary through the pharmacy benefit.

2. Retail—Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the pharmacy plan administrator. The pharmacy vendor will reimburse the cost of the drug based on the network discounted amount, less the applicable coinsurance.

A. Generic: Forty percent (40%) coinsurance after deductible for up to thirty (30)-day supply for a generic drug on the formulary.

B. Brand: Forty percent (40%) coinsurance after deductible for up to thirty (30)-day supply for a brand drug on the formulary.

C. Non-formulary: Fifty percent (50%) coinsurance after deductible for up to thirty (30)-day supply for a drug not on the formulary.

*[[2] If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug rather than the copayment.]*

*[[3]](2) Step Therapy—Step therapy requires that drug therapy for a medical condition begin with the most cost-effective and safest drug therapy before moving to other more costly therapy, if necessary. This program involves the member's physician and is only for members who take prescription drugs to treat certain ongoing medical conditions. The member is responsible for paying the full price for the prescription drug unless the member's physician prescribes a first step drug. If the member's physician decides for medical reasons that the member's treatment plan requires a different medication without attempting to use the first step drug, the physician may request a prior authorization from the pharmacy plan administrator. If the prior authorization is approved, the member is responsible for the applicable copayment which may be higher than the first step drug. If the requested prior authorization is not approved, then the member is responsible for the full price of the drug.*

#### (A) First Step—

1. Uses primarily generic drugs;
2. Lowest applicable copayment is charged; and
3. First step drugs must be used before the plan will authorize payment for second step drugs.

#### (B) Second Step—

1. This step applies if the member's treatment plan requires a different medication after attempting the first step medication;
2. Uses primarily brand-name drugs; and
3. Typically, a higher copayment amount is applicable.

*[[4] Prior Authorization—Certain medications are subject to prior authorization. Network pharmacies will notify the member if prior authorization is required. The member or the pharmacy must contact the pharmacy plan administrator before payment will be approved.]*

*[[5]](3) Filing of Claims—Claims must be filed within twelve (12) months of filling the prescription. Members may request claim forms from the plan or the pharmacy plan administrator. In order to file a*

claim, members must—

(A) Complete the claim form; *[and]*

(B) Attach a prescription receipt or label with the claim form. Patient history printouts from the pharmacy are acceptable but must be signed by the pharmacist. Cash register receipts are not acceptable for any prescriptions, except diabetic supplies. If attaching a receipt or label, the receipt or label shall include:

1. Pharmacy name and address;
2. Patient's name;
3. Price;
4. Date filled;
5. Drug name, strength, and national drug code (NDC);
6. Prescription number;
7. Quantity; and
8. Days' supply~~/.~~; and

(C) **Members must file a claim to receive reimbursement of the cost of a prescription filled at a non-network pharmacy. Non-network pharmacy claims are allowed at the network discounted price as determined by the vendor minus any applicable copayment. Members are responsible for any charge over the network discounted price and the applicable copayment.**

*[(6)](4)* **Formulary**—The formulary is updated on a semi-annual basis, or when—

(A) A generic drug becomes available to replace the brand-name drug. If this occurs, the generic copayment applies; or

(B) A drug becomes available over-the-counter. If this occurs, then the drug is no longer covered under the pharmacy benefit; or

(C) A drug is determined to have a safety issue.

*[(7)](5)* **[Limitation—Prescription drugs not listed on the formulary are not a covered benefit except for prescription drugs that have been grandfathered for members who have taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011. If the participant purchased a brand-name drug that is grandfathered when there is a Food and Drug Administration (FDA)-approved generic drug, the participant shall pay the generic copayment plus the difference in the brand and generic cost of the drug.]**  
**Grandfathered Specialty Drugs**—Prescription drugs grandfathered for members in 2011 because they had taken a grandfathered drug within one hundred thirty (130) days prior to January 1, 2011, will continue to be covered at a thirty-five-dollar (\$35) brand copayment level if enrolled in a PPO plan or at twenty percent (20%) coinsurance if enrolled in the HDHP plan. Grandfathered drugs include:

(A) Alzheimer's disease drugs;

(B) Antidepressants, including selective serotonin reuptake inhibitors (SSRIs) and selective serotonin and norepinephrine reuptake inhibitors (SNRIs);

(C) Anti-epileptics;

(D) **Attention-deficit hyperactivity disorder (ADHD);**

*[(D)](E)* **Biologics for inflammatory conditions;**

*[(E)](F)* **Cancer drugs;**

*[(F)](G)* **Hemophilia drugs (*/F*/factor VIII and IX concentrates);**

*[(G)](H)* **Hepatitis drugs;**

*[(H)](I)* **Immunosuppressants (transplant anti-rejection agents);**

*[(I)](J)* **Insulin (basal);**

*[(J)](K)* **Low molecular weight heparins;**

*[(K)](L)* **Multiple sclerosis injectable drugs;**

*[(L)](M)* **Novel psychotropics (oral products and long-active injectables);**

*[(M)](N)* **Phosphate binders;**

*[(N)](O)* **Pulmonary hypertension drugs; and**

*[(O)](P)* **Somatostatin analogs.**

*[(8)* **Under the High Deductible Health Plan (HDHP), pharmacy benefits are subject to the applicable medical plan**

*deductible and coinsurance.]*

(6) **Medicare Part B Prescription Drugs**—For covered Medicare Part B prescriptions, Medicare and MCHCP will coordinate to provide up to one hundred percent (100%) coverage for the drugs. To receive Medicare Part B prescriptions without a copayment or coinsurance, the subscriber must submit prescriptions and refills to an MCHCP vendor-contracted participating Medicare Part B retail pharmacy or use the MCHCP vendor-contracted home delivery service. Medicare Part B prescriptions include, but are not limited to, the following:

(A) Diabetes testing and maintenance supplies;

(B) Respiratory agents;

(C) Immunosuppressants; and

(D) Oral anti-cancer medications.

(7) **Quantity Level Limits**—Quantities of some medications may be limited based on recommendations by the Food and Drug Administration and medical literature. Limits are in place to ensure safe and effective drug use and guard against stockpiling of medicines.

(8) **Guidelines for Drug Use**—If MCHCP suspects drug misuse, abuse, or fraud, MCHCP reserves the right to pay only for those medications prescribed by an assigned physician approved by MCHCP.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2009, effective Jan. 1, 2010, expired June 29, 2010. Original rule filed Jan. 4, 2010, effective June 30, 2010. Emergency amendment filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Amended: Filed Dec. 22, 2010, effective June 30, 2011. Emergency amendment filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Amended: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions six hundred fifty-three thousand nine hundred sixty-three dollars (\$653,963) in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities eight hundred ninety-one thousand forty-nine dollars (\$891,049) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Name:</b>	<b>22 CSR 10-3.090 Pharmacy Benefit Summary</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003</b>	<b>\$653,963</b>

**III. WORKSHEET**

Estimated cost is the projected portion of the premium attributable to prescription drug coverage for 2012, calculated as 50 percent of the Active Employee Only premium for all public entity employees who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under MCHCP Plans as of August 1, 2011 (data used the CY2012 projection);
- Calendar year 2012 membership in all MCHCP Plans remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Actual claim costs will vary based upon actual utilization of services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.090 Pharmacy Benefit Summary</b>
<b>Type of Rulemaking:</b>	<b>Proposed Amendment</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>1,403 individuals enrolled in MCHCP public entity plans for CY 2012</b>	<b>Individuals enrolled in MCHCP public entity plans for CY 2012</b>	<b>\$891,049</b>

**III. WORKSHEET**

Estimated cost is the projected portion of the premium attributable to prescription drug coverage for 2012, calculated as 50 percent of the Active Employee Only premium for all public entity subscribers' premium, plus 100 percent of the additional premium for other levels of coverage for all public entity employees who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment in the MCHCP pharmacy plan as of August 1, 2011 (data used for the CY2012 projection);
- Calendar year 2012 membership in the MCHCP pharmacy plan remains relatively stable;
- Calendar year 2012 rates remain relatively stable.
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED RESCISSION**

**22 CSR 10-3.092 Dental Benefit Summary.** This rule established the policy of the board of trustees in regard to the dental benefit summary for members of the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded and readopted to clarify the dental benefit is governed by a fully-insured plan.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Rescinded: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED RULE**

**22 CSR 10-3.092 Dental Coverage**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to dental coverage for members of the Missouri Consolidated Health Care Plan.*

(1) The plan administrator may offer dental coverage through a vendor.

(A) Dental plan design is defined by the vendor.

(B) Dental plan eligibility, enrollment, and termination requirements are determined by the plan administrator and are defined in 22 CSR 10-3.020.

(C) Total dental premium costs for all coverage levels are fully paid by the member and/or public entity and collected by the plan administrator.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Rescinded and readopted: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rule will cost state agencies or political subdivisions sixty thousand one hundred sixty dollars (\$60,160) in the aggregate.*

*PRIVATE COST: This proposed rule will cost private entities four hundred thirty-five thousand seven hundred ninety-six dollars (\$435,796) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: 22 - Missouri Consolidated Health Care Plan  
Division Title: Division 10  
Chapter Title: Chapter 3**

<b>Rule Number and Name:</b>	<b>22 CSR 10-3.092 Dental Benefit Summary</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>Missouri Consolidated Health Care Plan and participating member agencies under Section 103.003</b>	<b>\$60,160</b>

**III. WORKSHEET**

Estimated cost is the annual cost of 50 percent of the Active Employee Only public entity premium for public entity employees who enroll for coverage under this plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment under the all public entity plans as of August 1, 2011;
- Calendar year 2012 membership in the public entity dental plans remain relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Calculations assume each public entity enrolled in the dental plan is contributing 50 percent toward the employee only monthly premium;
- Actual claim costs will vary based upon actual utilization of services.

## FISCAL NOTE PRIVATE COST

- I. Department Title: 22 – Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.092 Dental Benefit Summary</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

## **II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>674 individuals enrolled in MCHCP Public Entity Dental Plan for CY 2012</b>	<b>Individuals enrolled in the MCHCP Public Entity Dental Plan for CY 2012</b>	<b>\$435,796</b>

## **III. WORKSHEET**

Estimated cost is the annual cost for public entity subscribers' premium costs for dental coverage for calendar year 2012. The public entity must contribute at least fifty percent toward the employee only month premium for the dental plan. Dental coverage is limited to a \$1,000 per person calendar year benefit.

## **IV. ASSUMPTIONS**

- Total enrollment in the public entity dental plans as of August 1, 2011 (data used for the CY2012 projection);
- Calendar year 2012 membership in the public entity dental plans remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Calculations assume each public entity enrolled in the dental plan is contributing 50 percent toward the employee only monthly premium;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.



**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED RESCISSION**

**22 CSR 10-3.093 Vision Benefit Summary.** This rule established the policy of the board of trustees in regard to the vision benefit summary for members of the Missouri Consolidated Health Care Plan.

*PURPOSE: This rule is being rescinded and readopted to clarify the vision benefit is governed by a fully-insured plan.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Rescinded: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED RULE**

**22 CSR 10-3.093 Vision Coverage**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to vision coverage for members of the Missouri Consolidated Health Care Plan.*

(1) The plan administrator may offer vision coverage through a vendor.

(A) Vision plan design is defined by the vendor.

(B) Vision plan eligibility, enrollment, and termination requirements are determined by the plan administrator and are defined in 22 CSR 10-3.020.

(C) Total vision premium costs for all coverage levels are fully paid by the member and/or public entity and collected by the plan administrator.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 22, 2010, effective Jan. 1, 2011, expired June 29, 2011. Original rule filed Dec. 22, 2010, effective June 30, 2011. Rescinded and readopted: Filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rule will cost private entities one hundred twenty thousand five hundred fifty-five dollars (\$120,555) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: 22 – Missouri Consolidated Health Care Plan**  
**Division Title: Division 10**  
**Chapter Title: Chapter 3**

<b>Rule Number and Title:</b>	<b>22 CSR 10-3.093 Vision Benefit Summary</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
<b>1,159 individuals enrolled in MCHCP Public Entity Vision Plan for CY 2012</b>	<b>Individuals enrolled in the MCHCP Public Entity Vision Plan for CY 2012</b>	<b>\$120,555</b>

**III. WORKSHEET**

Estimated cost is the annual cost for public entity subscribers' premium costs for the vision plan for calendar year 2012.

**IV. ASSUMPTIONS**

- Total enrollment in the public entity vision plan as of August 1, 2011 (data used for the CY2012 projection);
- Calendar year 2012 membership in the public entity vision plan remains relatively stable;
- Calendar year 2012 rates remain relatively stable;
- Actual claim costs for individual subscribers will vary based upon actual utilization of services. The above summary of fiscal impact does not include out-of-pocket costs that members will incur at the time of service.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**PROPOSED RULE**

**22 CSR 10-3.100 Fully-Insured Medical Plan Provisions**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to the fully-insured plan provisions of the Missouri Consolidated Health Care Plan relative to public entities and public entity members.*

(1) A fully-insured medical plan is subject to applicable Department of Insurance, Financial Institutions and Professional Registration (DIFP) statutes and regulations. Members enrolled in a fully-insured medical plan will have rights and responsibilities as provided in those applicable statutes and regulations. If and to the extent there is a conflict between the plan and DIFP statutes and regulations, DIFP statutes and regulations shall prevail. Governing DIFP statutes and regulations include but are not limited to appeals, timelines, and payments.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Nov. 1, 2011, effective Jan. 1, 2012, expires June 28, 2012. Original rule filed Nov. 1, 2011.*

*PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**T**his section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order or rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

**T**he agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety (90)-day period during which an agency shall file its order of rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the proposed rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

## Title 2—DEPARTMENT OF AGRICULTURE Division 90—Weights and Measures Chapter 10—Liquefied Petroleum Gases

### ORDER OF RULEMAKING

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission amends a rule as follows:

#### 2 CSR 90-10.001 Definitions and General Provisions is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1741). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## Title 2—DEPARTMENT OF AGRICULTURE Division 90—Weights and Measures Chapter 10—Liquefied Petroleum Gases

### ORDER OF RULEMAKING

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission amends a rule as follows:

#### 2 CSR 90-10.011 Inspection Authority—Duties is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1741–1742). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The commission received one (1) comment on this proposed amendment.

COMMENT: Charles Gohring, Missouri Department of Transportation, Motor Carrier Services, suggested language that would void the rule if it was determined to be in conflict with “any federal constitutional, statutory or regulatory provisions that would result in the loss of any federal funds to the state of Missouri.”

RESPONSE: The commission did not recommend changes based on the comment and did not make any changes to the amendment.

## Title 2—DEPARTMENT OF AGRICULTURE Division 90—Weights and Measures Chapter 10—Liquefied Petroleum Gases

### ORDER OF RULEMAKING

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission amends a rule as follows:

#### 2 CSR 90-10.012 Registration—Training is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1742–1743). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The commission received two (2) comments on this proposed amendment.

COMMENT #1: Charles Gohring, Missouri Department of Transportation, Motor Carrier Services, suggested language that would void the rule if it was determined to be in conflict with “any federal constitutional, statutory or regulatory provisions that would result in the loss of any federal funds to the state of Missouri.”

RESPONSE: The commission did not recommend changes based on the comment and did not make any changes to the amendment.

COMMENT #2: Mr. Gohring also questioned whether common or contract motor carriers would be required to meet the registration and training provisions of Class I which might preempt federal hazardous materials regulations.

RESPONSE: Class I is designed for General LP gas operators, not common or contract carriers. The classification addresses the storage, sale, transportation, and distribution at retail-wholesale. The commission did not recommend changes based on the comment and did not make any changes to the amendment.

## Title 2—DEPARTMENT OF AGRICULTURE Division 90—Weights and Measures Chapter 10—Liquefied Petroleum Gases

### ORDER OF RULEMAKING

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission amends a rule as follows:

**2 CSR 90-10.013 Installation Requirements is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1743-1745). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The commission received one (1) comment on this proposed amendment.

COMMENT: Charles Gohring, Missouri Department of Transportation, Motor Carrier Services, suggested language that would void the rule if it was determined to be in conflict with “any federal constitutional, statutory or regulatory provisions that would result in the loss of any federal funds to the state of Missouri.”  
RESPONSE: The commission did not recommend changes based on the comment and did not make any changes to the amendment.

**Title 2—DEPARTMENT OF AGRICULTURE  
Division 90—Weights and Measures  
Chapter 10—Liquefied Petroleum Gases**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission amends a rule as follows:

**2 CSR 90-10.014 Storage is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1745-1746). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The commission received one (1) comment on this proposed amendment.

COMMENT: Charles Gohring, Missouri Department of Transportation, Motor Carrier Services, suggested language that would void the rule if it was determined to be in conflict with “any federal constitutional, statutory or regulatory provisions that would result in the loss of any federal funds to the state of Missouri.”  
RESPONSE: The commission did not recommend changes based on the comment and did not make any changes to the amendment.

**Title 2—DEPARTMENT OF AGRICULTURE  
Division 90—Weights and Measures  
Chapter 10—Liquefied Petroleum Gases**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission amends a rule as follows:

**2 CSR 90-10.015 Container, System, or Equipment Violations is amended.**

A notice of proposed rulemaking containing the text of the proposed

amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1746). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 2—DEPARTMENT OF AGRICULTURE  
Division 90—Weights and Measures  
Chapter 10—Liquefied Petroleum Gases**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission amends a rule as follows:

**2 CSR 90-10.020 NFPA Manual No. 54, National Fuel Gas Code is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1746-1747). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 2—DEPARTMENT OF AGRICULTURE  
Division 90—Weights and Measures  
Chapter 10—Liquefied Petroleum Gases**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission amends a rule as follows:

**2 CSR 90-10.040 NFPA Manual No. 58, Storage and Handling of Liquefied Petroleum Gases is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1747). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The commission received one (1) comment on this proposed amendment.

COMMENT: Charles Gohring, Missouri Department of Transportation, Motor Carrier Services, suggested language that would void the rule if it was determined to be in conflict with “any federal constitutional, statutory or regulatory provisions that would result in the loss of any federal funds to the state of Missouri.”  
RESPONSE: The commission did not recommend changes based on the comment and did not make any changes to the amendment.

**Title 2—DEPARTMENT OF AGRICULTURE  
Division 90—Weights and Measures  
Chapter 10—Liquefied Petroleum Gases**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission rescinds a rule as follows:

**2 CSR 90-10.060** NFPA Manual No. 59, *LP Gases at Utility Gas Plants* **is rescinded.**

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1748). No changes have been made to the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 2—DEPARTMENT OF AGRICULTURE**  
**Division 90—Weights and Measures**  
**Chapter 10—Liquefied Petroleum Gases**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission rescinds a rule as follows:

**2 CSR 90-10.070** NFPA Manual No. 501A, *Manufactured Home Installations* **is rescinded.**

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1748). No changes have been made to the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 2—DEPARTMENT OF AGRICULTURE**  
**Division 90—Weights and Measures**  
**Chapter 10—Liquefied Petroleum Gases**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission amends a rule as follows:

**2 CSR 90-10.090** NFPA Manual No. 1192, Chapter 5, *Standard for Recreational Vehicles* **is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1748). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 2—DEPARTMENT OF AGRICULTURE**  
**Division 90—Weights and Measures**  
**Chapter 10—Liquefied Petroleum Gases**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Propane Gas Commission under section 323.060, RSMo Supp. 2010, the commission adopts a rule as follows:

**2 CSR 90-10.120** Reporting of Odorized LP-Gas Release, Fire, or Explosion **is adopted.**

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1748–1749). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 6—DEPARTMENT OF HIGHER EDUCATION**  
**Division 10—Commissioner of Higher Education**  
**Chapter 11—Nursing Education Incentive Program**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Higher Education under section 335.203(5), RSMo, HB 233, First Regular Session, Ninety-sixth General Assembly, 2011, the department adopts a rule as follows:

**6 CSR 10-11.010** is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on August 15, 2011 (36 MoReg 1894–1895). The section with changes is reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Higher Education received nine (9) comments on the proposed rule.

Due to similar concerns in the following nine (9) comments, one (1) response can be found at the end of comment #9.

COMMENT #1: Zora Mulligan, Executive Director of the Missouri Community College Association, requested that language in the rule limiting eligible institutions of higher education to those offering the bachelor's degree or higher degrees be stricken to allow community colleges to be eligible to apply for grants in the program.

COMMENT #2: Pam McIntyre, President of St. Louis Community College—Westwood, objected to the rule's exclusion of community colleges from eligibility to apply for the program.

COMMENT #3: Marcia Pfeiffer, President of St. Louis Community College—Florissant Valley, objected to the rule's exclusion of community colleges from eligibility to apply for the program.

COMMENT #4: Steven Kurtz, President of Mineral Area College, objected to the rule's exclusion of community colleges from eligibility to apply for the program.

COMMENT #5: Jeff Jochems, President of Ozarks Technical Community College—Richwood Valley campus, objected to the rule's exclusion of community colleges from eligibility to apply for the program.

COMMENT #6: Marsha Drennon, President of State Fair Community College, objected to the rule's exclusion of community colleges from eligibility to apply for the program.

COMMENT #7: Neil Nuttall, President of North Central Missouri College, objected to the rule's exclusion of community colleges from eligibility to apply for the program.

COMMENT #8: Raymond Cumiskey, President of Jefferson College, objected to the rule's exclusion of community colleges from eligibility to apply for the program.

COMMENT #9: Cindy K. Hess, President of St. Louis Community College—Forest Park, objected to the rule’s exclusion of community colleges from eligibility to apply for the program.

RESPONSE AND EXPLANATION OF CHANGE: The department agrees that the rule imposes a restriction on potential applicants that is beyond the restrictions included in the enabling legislation. The rule has been changed to remove this restriction.

#### 6 CSR 10-11.010 Nursing Education Incentive Program

(2) Institutional Criteria for Grant Awards. To be eligible to receive a Nursing Education Incentive Grant, the applicant must meet the following eligibility criteria:

(A) Be a Missouri institution of higher education (sponsoring institution) offering a program of professional nursing;

### Title 11—DEPARTMENT OF PUBLIC SAFETY Division 45—Missouri Gaming Commission Chapter 5—Conduct of Gaming

#### ORDER OF RULEMAKING

By the authority vested in the Missouri Gaming Commission under section 313.805, RSMo Supp. 2010, the commission adopts a rule as follows:

11 CSR 45-5.194 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1615–1616). The section with changes is reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing was held on this proposed rule on August 10, 2011. No one commented at the public hearing. Written comments were received from Bally and International Game Technology (IGT).

#### Bally’s comments—

COMMENT #1: Bally’s comment for 11 CSR 45-5.194(4)(B)—“Bally disagrees with an arbitrary percent limitation of 30%. Since the player can minimize the screen at any time the player should not be limited to size of screen for System Window.”

RESPONSE: The commission has rules governing the clarity of information displayed on Electronic Gaming Device(s). The 30% rule was based on commission field observation. As stated in 11 CSR 45-7.040(2) and GLI 112.0–4.10.2, our jurisdiction requires the clarity of the screen and patron access to help screen menus.

COMMENT #2: An additional comment received on August 5, 2011, from Bally states: “With regard to the one concern that seems to remain after our discussion, will it be possible to at least change the regulation to add something like, unless the ‘Commission approves otherwise;’ unless of course it can be eliminated altogether which is our preference.”

RESPONSE AND EXPLANATION OF CHANGE: The commission agrees with Bally’s comment, therefore the rule has been revised to accommodate unforeseen technology.

COMMENT #3: 11 CSR 45-5.194(10)—While Bally is not currently submitting such a product to the Missouri Gaming Commission, it is our position that use of the Operator Content Delivery System (OCDS) for second chance to play games should not be prohibited in regulations providing that it complies with current regulations or that additional regulations and rules would be needed. We are in disagreement with this being established as policy.

RESPONSE: The OCDS rules have been established based on feedback from Missouri Class A Licensees. At this juncture, no one has expressed interest in implementing this technology beyond what has been annotated in 11 CSR 45-5.194. The expansion of 11 CSR 45-5.194 would give rise to policy concerns regarding repurposing of meters. To date, the commission is unaware of any meter schema that has been specifically designed to account for secondary gambling products. Additionally, permitting patrons to wager points would give rise to indirect consideration to a gambling game.

#### IGT’s comments—

COMMENT #4: IGT requests clarification regarding 11 CSR 45-5.194(6)(D) to understand what is considered by “all critical memory” and how does this impact the communication to an “external device” if the integrity check were to fail following the established connection to an external device?

RESPONSE: “All critical memory” pertains to the memory within the system window rendering device which contains the data required for the device to function properly. The integrity check likely will happen upon boot-up of the system window rendering device since it must happen prior to any external communication. Should the integrity check fail, the system window rendering device shall not establish a communication link to an external device. If the system window rendering device is designed to perform an integrity check in addition to the boot-up integrity check, and the device fails the integrity check, any external communication should cease until the device can successfully pass the integrity check.

COMMENT #5: IGT suggests that 11 CSR 45-5.194(10) be expanded to allow the usage of a player’s earned “Promotional Giveaway Credits” and “Player Reward Credits” for the opportunity for a player to wager the points for a chance to earn additional promotional awards rather than restrict the usage. The capability to convert “Promotional Giveaway Credits” and “Player Reward Credits” to either Non-Cashable Electronic Promotion (NCEP) or Cashable Electronic Promotion (CEP) for Electronic Gaming Machine (EGM) wagering as outlined in Missouri’s Minimum Internal Control Standards Chapter U is allowed today. IGT contends that the ability to wager promotional awards at the system window is an extension of today’s accepted NCEP/CEP wagering practices.

RESPONSE: The OCDS rules have been established based on feedback from Missouri Class A Licensees. At this juncture, no one has expressed interest in implementing this technology beyond what has been annotated in 11 CSR 45-5.194. IGT’s recommendations would give rise to policy concerns regarding the wagering of promotional giveaway credits and player reward credits, as defined by Chapter 572, RSMo. Permitting patrons to wager giveaway credits and player reward credits would give rise to indirect consideration to a secondary non-tax, non-regulated gambling game.

#### 11 CSR 45-5.194 Operator Content Delivery Systems

(4) A system window being displayed during game play shall not, unless otherwise approved in writing—

### Title 13—DEPARTMENT OF SOCIAL SERVICES Division 70—MO HealthNet Division Chapter 15—Hospital Program

#### ORDER OF RULEMAKING

By the authority vested in the MO HealthNet Division under sections 208.152, 208.153, and 208.201, RSMo Supp. 2010, the division amends a rule as follows:

**13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1616-1619). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 13—DEPARTMENT OF SOCIAL SERVICES  
Division 70—MO HealthNet Division  
Chapter 15—Hospital Program**

**ORDER OF RULEMAKING**

By the authority vested in the MO HealthNet Division under sections 208.201 and 208.453, RSMo Supp. 2010, and section 208.455, RSMo 2000, the division amends a rule as follows:

**13 CSR 70-15.110 Federal Reimbursement Allowance (FRA) is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2011 (36 MoReg 1840-1842). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The MO HealthNet Division (MHD) received two (2) comments from the Missouri Hospital Association.

COMMENT #1: A comment was received indicating that pending litigation in Cole County Circuit Court challenging the emergency regulations 13 CSR 70-15.010 and 13 CSR 70-15.220 generates significant uncertainty about the state's ability to make certain payments to hospitals that would have been funded by the increase in the FRA assessment from five and forty-five hundredths percent (5.45%) to five and ninety-five hundredths percent (5.95%). If the payments are delayed or blocked by the court's actions, the commentator believes it would be financially disruptive to Missouri hospitals to proceed with collecting the increased FRA. The commentator suggested the FRA assessment rate should be lowered from the proposed five and ninety-five hundredths percent (5.95%) to an amount necessary to fund payments associated with anticipated growth in service volume and ensure funding for payments made during the first quarter of SFY 2012. The commentator further suggested once the litigation is resolved the Department of Social Services could take action to raise the FRA assessment at that time. The commentator stated that to the extent the FRA revenues could be used as authorized by state and federal regulation to support payment streams that are not put at risk by the pending litigation, they would be pleased to discuss this.

RESPONSE: MHD has historically based the FRA assessment at a rate sufficient to cover the authorized projected payments for that state fiscal year (SFY). MHD determined that the FRA assessment rate sufficient to cover the projected payments for SFY 2012 including, but not limited, to those authorized by the emergency and proposed amendments to 13 CSR 70-15.010 and 13 CSR 70-15.220, is five and ninety-five hundredths percent (5.95%). While MHD understands the uncertainty felt by the hospital industry as a result of the aforementioned litigation, MHD is unable to reduce the FRA assessment below five and ninety-five hundredths percent (5.95%) at

this time because it was determined to be the rate necessary to cover the projected payments for SFY 2012. Unless MHD is ordered by the court to change the hospital payments authorized in the emergency amendments to 13 CSR 70-15.010 or 13 CSR 70-15.220, the payments set forth in those amendments will continue, supporting the need for the FRA assessment rate of five and ninety-five hundredths percent (5.95%). MHD also does not have a basis to change the proposed amendment to 13 CSR 70-15.010 to revise hospital payments set forth in the amendment because no comments were received during the allotted comment period. Therefore, the hospital payments authorized under the proposed amendment to 13 CSR 70-15.010 will continue, supporting the need for the FRA assessment rate of five and ninety-five hundredths percent (5.95%). As stated above, MHD will continue to make hospital payments authorized by the various hospital regulations. However, if MHD is ordered by the court to stop hospital payments authorized in emergency amendments 13 CSR 70-15.010 and/or 13 CSR 70-15.220, MHD will reevaluate using the FRA revenues generated from the increase to fund authorized hospital payments that are not put at risk by the litigation. If the court orders payments to be reduced, MHD plans to either file an emergency amendment to reduce the tax to the amount needed to fund payments at the level ordered by the court or fund payments otherwise authorized. No changes have been made to the amendment as a result of this comment.

COMMENT #2: A comment was received indicating MHD might need to consider regulatory changes to address the unusual circumstances of incorporating Shriners Hospital for Children (Shriners) into the FRA program. Ordinarily, a hospital which does not have a fourth prior-year cost report would have its taxable revenue for purposes of the FRA defined using a formula based on the hospital's number of licensed beds. The commentator believes that due to the historic mission and specialized treatment of services of Shriners' hospital, this formula would generate an untoward result.

RESPONSE: MHD does not believe that a regulatory change is necessary to incorporate Shriners into the FRA program in a reasonable manner. MHD recognizes Shriners' unusual circumstances and believes it can determine a reasonable assessment under the current FRA rule. No changes have been made to the amendment as a result of this comment.

**Title 13—DEPARTMENT OF SOCIAL SERVICES  
Division 70—MO HealthNet Division  
Chapter 15—Hospital Program**

**ORDER OF RULEMAKING**

By the authority vested in the MO HealthNet Division under sections 208.152, 208.153, and 208.201, RSMo Supp. 2010, the division adopts a rule as follows:

13 CSR 70-15.220 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1620-1623). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The MO HealthNet Division (MHD) received several comments from Lashly & Baer, P.C.

COMMENT #1: A comment was received indicating that the methodology for calculating Disproportionate Share Hospital (DSH) payments was not contained in the proposed rule.

RESPONSE AND EXPLANATION OF CHANGE: MHD has amended sections (4), (5), and (7) to provide additional detail on how



Disproportionate Share Hospital Payments (DSH) payments are calculated.

COMMENT #2: A comment was received indicating the following terms referenced in subsection (1)(D) are not defined: uncompensated care costs, DSH limit, and DSH costs.

RESPONSE AND EXPLANATION OF CHANGE: MHD modified the term “DSH costs” for clarity and consistency and also amended the term “DSH limit” throughout the rule for consistency purposes. MHD amended subsection (1)(D), section (4), and added section (10) to define the terms used in the rule.

COMMENT #3: A comment was received indicating the statement in subsection (1)(D) “Hospital-specific DSH limit calculations must comply with federally-mandated DSH audit standards and definitions” is not accurate because the DSH limit calculations and DSH audit standards are separate requirements.

RESPONSE AND EXPLANATION OF CHANGE: MHD used this phrase to indicate that the estimated hospital-specific DSH limit must be calculated in a manner to ensure that DSH payments do not exceed the hospital-specific DSH limit using the federally-mandated DSH audit standards and definitions set forth in the federal DSH rules. MHD has amended subsection (1)(D) to clarify that the hospital-specific DSH limit calculations must comply with the federal DSH rules.

COMMENT #4: A comment was received indicating the title to section (4) “DSH Audit Payment Adjustment” is misleading because no audit or verification procedures for the payment adjustment are referenced in the rule.

RESPONSE AND EXPLANATION OF CHANGE: MHD used this term to indicate that the DSH payment adjustments are necessary to be in compliance with the federal DSH audit rules. The federal DSH audit rules and Centers for Medicare and Medicaid Services (CMS) guidance prescribe states to consider the findings from the 2005, 2006, and 2007 independent DSH audits when calculating uncompensated care cost estimates and associated DSH payments beginning with Medicaid State Plan rate year 2011. The results of those independent audits indicated that the DSH cost and payment methodology used by MHD would not comply with the hospital-specific DSH limit standards. Therefore, it was determined that a change in DSH cost and payment methodology was warranted. To reflect the methodology change for the state fiscal year (SFY) 2011 DSH payments, the adjustments set forth in this section are necessary. To avoid confusion, MHD has amended section (4) to remove the word “Audit” from the title.

COMMENT #5: A comment was received indicating the statement in subsection (4)(A) “payments...will be revised based on...DSH survey which uses federally-mandated DSH audit standards.” implies the use of a survey complies with the federal DSH rule. The commentor believes the federal DSH rule makes no reference to using a “DSH Survey” to determine the DSH limit. The commentor goes on to say this statement is not accurate because there were no audit standards applied to the hospital-submitted DSH surveys and that those audit standards require testing and verification of the DSH limit calculations which the commentor believes MHD has not done.

RESPONSE AND EXPLANATION OF CHANGE: As indicated in a previous Comment and Response, MHD used the phrase “DSH survey which uses federally-mandated DSH audit standards” to indicate that the DSH calculations must be performed in accordance with the federal DSH rules. While the federal DSH rules do not explicitly state that a DSH survey must be used, the federal DSH rules require that the state’s DSH payments must comply with the federal DSH rules, so MHD developed a state DSH survey to calculate interim DSH payments that are in compliance with the federal DSH rules. States are given considerable flexibility in developing DSH payment methodologies but are limited by the annual DSH allotment and the

costs used to determine the hospital-specific DSH limits. MHD believes changing the current methodology and collecting the needed data through the use of the state DSH survey will allow it to determine interim DSH payments that comply with the federal DSH rules. A transition period was authorized by the federal DSH rules in that independent certified DSH audits for Medicaid State Plan rate years 2005–2010 would not be given weight except to the extent that the findings draw into question the reasonableness of the state’s uncompensated care cost estimates used for calculating prospective DSH payments for Medicaid State Plan rate year 2011 and thereafter. The federal DSH rules and CMS guidance prescribe states to consider the findings from the 2005, 2006, and 2007 independent DSH audits when calculating uncompensated care cost estimates and associated DSH payments beginning with Medicaid State Plan rate year 2011. The results of those independent audits indicated that the DSH cost and payment methodology used by MHD would not comply with the hospital-specific DSH limit standards. Therefore, it was determined that a change in DSH cost and payment methodology was warranted. Given the age of the 2005, 2006, and 2007 independent DSH audit data the state determined it needed to use more recent data to make further adjustments to their SFY 2011 DSH payments. Since 2007, MHD has made cuts in Medicaid payments to hospitals resulting in larger hospital-specific DSH limits. Therefore, the MHD developed a DSH survey similar to the DSH survey utilized by the independent auditor during the federally-mandated annual independent DSH audit which is required by the federal DSH rules. The state DSH survey was designed to collect more recent cost and payment information on a hospital-specific basis. It also reflects the standards of calculating uncompensated care cost established by the federal DSH rules. Furthermore, on page 77908 of the December 19, 2008, *Federal Register*, CMS provided a response to a comment stating in part “Typically, States currently rely on unaudited surveys to estimate uncompensated care in eligible hospitals, and this regulation would simply require reconciliation based on statutory cost limits using a more accurate audit methodology.” MHD believes this further supports its use of the state DSH survey as a data collection tool and that it is not not required to be audited. The federal DSH rules do not require the state to perform an audit of the data prior to the DSH payments being made. The federal DSH rules require an independent audit to be performed on actual DSH payments and costs three (3) years after the DSH payments are made. MHD has amended subsection (4)(A) to provide clarification. Furthermore, MHD discussed with CMS staff whether the use of a state DSH survey to determine interim DSH payments in compliance with the federal DSH rules would be allowable, and they indicated it would. CMS also approved the state’s Medicaid State Plan amendment which provides for the use of the state DSH survey in calculating interim DSH payments.

COMMENT #6: A comment was received indicating the federal DSH rule requires that the DSH limit be determined in accordance with federal accounting standards and Medicare reasonable cost principles. The commentor stated that Medicare reasonable cost principles require that provider (FRA) taxes paid be reduced by (FRA) payments received that are associated with the assessed tax, such that reasonable costs are limited to the net tax expense. It is the commentor’s understanding that the survey does not apply this principle and, therefore, does not comply with the federal DSH rule.

RESPONSE AND EXPLANATION OF CHANGE: MHD followed federal accounting standards and Medicare reasonable cost principles and followed guidance from CMS concerning the treatment of the provider (FRA) taxes when developing the survey and DSH payment methodologies. Furthermore, on page 77923 of the December 19, 2008, *Federal Register*, CMS provided a response to a comment on provider taxes stating “Existing Medicaid policy recognizes permissible health care taxes as an allowable cost for the purposes of Medicaid reimbursement. A portion of a permissible hospital tax may also be allocated to indigent care days as part of the hospital cost report step-down cost allocation process. Specifically, the portion of

a permissible health care related tax allocated to the cost of providing inpatient and outpatient hospital services to patients with no source of third party coverage may be included in the hospital-specific DSH limit.” MHD added section (10) to provide clarification on the uncompensated care costs and Medicare cost reporting methodologies included in calculating the estimated hospital-specific DSH limit.

**COMMENT #7:** A comment was received indicating that subsection (4)(A) does not describe the state’s calculations or methodology to determine the payment revisions based on the survey or the methodology for analyzing the 2011 state’s DSH survey and limiting DSH payments to hospitals.

**RESPONSE AND EXPLANATION OF CHANGE:** MHD amended section (4) to provide additional detail on the state’s calculations using the 2011 state DSH survey to calculate and revise DSH payments.

**COMMENT #8:** A comment was received indicating that subsection (4)(A) refers to a DSH survey but does not contain the requirement for hospitals to submit a DSH survey or the process to be followed for hospitals in completing the DSH survey.

**RESPONSE AND EXPLANATION OF CHANGE:** MHD added section (9) to provide guidance on the completion and submission of the DSH survey.

**COMMENT #9:** A comment was received indicating paragraph (4)(A)2. does not identify the process for recouping DSH payments that exceed the projected DSH limit nor explain the methodology for determining a hospital’s projected DSH limit.

**RESPONSE AND EXPLANATION OF CHANGE:** MHD amended section (4) to identify the process for recouping DSH payments that exceeded the estimated hospital-specific DSH limit and amended sections (4) and (5) to provide additional detail on the methodology used for determining a hospital’s estimated hospital-specific DSH limit.

**COMMENT #10:** A comment was received indicating the reference in subsection (4)(B) to redistribution of DSH payments based on the surveys does not comply with the federal DSH rule unless the reference to DSH audit is to the independent certified audit in 2014 of SFY 2011. The federal DSH rule provides for redistribution in connection with independent certified audits, not surveys.

**RESPONSE AND EXPLANATION OF CHANGE:** MHD believes the interim adjustments resulting in redistributions set forth in subsection (4)(B) do comply with the federal DSH rules. The federal DSH rules and CMS guidance prescribe states to consider the findings from the 2005, 2006, and 2007 independent DSH audits when calculating uncompensated care cost estimates and associated DSH payments for Medicaid State Plan rate year 2011. The results of those independent audits indicated that the DSH cost and payment methodology used by MHD would not comply with the hospital-specific DSH limit standards. Therefore, it was determined that a change in DSH cost and payment methodology was warranted. To reflect the methodology change for the SFY 2011 DSH payments, the adjustments set forth in this section are necessary. CMS also approved the state’s Medicaid State Plan amendment which provides for the interim adjustments and redistribution of DSH payments based on a state DSH survey. MHD has amended section (4) to provide clarification on the redistribution process.

**COMMENT #11:** A comment was received indicating the SFY 2012 interim DSH payments found in subsection (5)(A) does not comply with the federal DSH rule due to the use of a survey rather than the independent certified audit.

**RESPONSE:** MHD believes the use of the state DSH survey complies with the federal DSH rules. States are given considerable flexibility in developing DSH payment methodologies but are limited by the annual DSH allotment and the costs used to determine the hos-

pital-specific DSH limits. While the federal DSH rules do not explicitly state that a DSH survey must be used, the federal DSH rules require that the state’s DSH payments must comply with the federal DSH rules. The federal DSH rules and CMS guidance prescribe states to consider the findings from the 2005, 2006, and 2007 independent DSH audits when calculating uncompensated care cost estimates and associated DSH payments for Medicaid State Plan rate year 2011. The results of those independent audits indicated that the DSH cost and payment methodology used by MHD would not comply with the hospital-specific DSH limit standards. Therefore, it was determined that a change in DSH cost and payment methodology was warranted. Given the age of independent DSH audit data the state was to consider, it was determined that the state needed to use more recent data to make further adjustments to their SFY 2011 DSH payments. Since 2007, MHD has made cuts in Medicaid payments to hospitals resulting in larger hospital-specific DSH limits. Therefore, the MHD developed a DSH survey similar to the DSH survey utilized by the independent auditor during the federally-mandated annual independent DSH audit which is in compliance with the federal DSH rules. The DSH survey was designed to collect more recent cost and payment information on a hospital-specific basis. It also reflects the standards of calculating uncompensated care cost established by the federal DSH rules. Furthermore, on page 77908 of the December 19, 2008, *Federal Register*, CMS provided a response to a comment stating in part “Typically, States currently rely on unaudited surveys to estimate uncompensated care in eligible hospitals, and this regulation would simply require reconciliation based on statutory cost limits using a more accurate audit methodology.” CMS also approved the state’s Medicaid State Plan amendment which provides for the use of the state DSH survey in calculating interim DSH payments. No changes have been made to the amendment as a result of this comment.

**COMMENT #12:** A comment was received indicating the SFY 2012 interim DSH payments found in subsection (5)(A) do not explain the methodology used to calculate interim 2012 DSH payments.

**RESPONSE AND EXPLANATION OF CHANGE:** MHD amended section (5) to provide additional detail regarding the methodology used to calculate interim DSH payments.

**COMMENT #13:** A comment was received indicating the SFY 2012 interim DSH payments found in subsection (5)(A) are not consistent with the process followed by the SFY 2011 DSH survey because the trends applied to SFY 2012 do not consider volume increases that were applied by hospitals in 2011.

**RESPONSE:** The state’s 2011 DSH survey allowed hospitals to apply hospital-specific adjustments for both inflation/trend and volume changes to reflect each individual hospital’s expected experience between the 2009 data and 2011. Since the SFY 2012 interim DSH payments were calculated by trending the 2011 DSH surveys, the individual hospital-specific adjustments were incorporated into the SFY 2012 interim DSH payments. No changes have been made to the amendment as a result of this comment.

**COMMENT #14:** A comment was received indicating the SFY 2012 interim DSH payments found in subsection (5)(A) do not comply with Medicare cost reimbursement principles as they relate to the handling of FRA taxes and FRA payments.

**RESPONSE AND EXPLANATION OF CHANGE:** MHD followed federal accounting standards and Medicare reasonable cost principles and followed guidance from CMS concerning the treatment of the provider (FRA) taxes when developing the survey and DSH payment methodologies. Furthermore, on page 77923 of the December 19, 2008, *Federal Register*, CMS provided a response to a comment on provider taxes stating “Existing Medicaid policy recognizes permissible health care taxes as an allowable cost for the purposes of Medicaid reimbursement. A portion of a permissible hospital tax may also be allocated to indigent care days as part of the hospital cost

report step-down cost allocation process. Specifically, the portion of a permissible health care related tax allocated to the cost of providing inpatient and outpatient hospital services to patients with no source of third party coverage may be included in the hospital-specific DSH limit." MHD added section (10) to provide clarification on the uncompensated care costs and Medicare cost reporting methodologies included in calculating the estimated hospital-specific DSH limit and interim DSH payments.

COMMENT #15: A comment was received indicating the terminology in subsection (7)(A) "Final DSH 'Adjustments'" should be changed to "recoupments" to be consistent with the terminology found in paragraph (4)(A)2.

RESPONSE: MHD does not believe this change is appropriate. The "Final DSH Adjustments" referenced in section (7) may result in either an overpayment subject to recoupment or an additional DSH payment depending on the results of the annual independent DSH audit. Paragraph (4)(A)2. uses the term "recouped" related to DSH payments that exceed the estimated hospital-specific DSH limit which are considered overpayments subject to recoupment. No changes have been made to the amendment as a result of this comment.

COMMENT #16: A comment was received questioning if the amount recouped by the interim adjustment under paragraph (4)(A)2. would be repaid to a hospital if the independent DSH audit in 2014 shows the the amount recouped as the interim adjustment was too much, and the hospital is determined to have been paid below its DSH limit for 2011.

RESPONSE: The amount recouped from a hospital as a result of the interim adjustment will not necessarily be repaid to a hospital even if the results of the independent DSH audit in 2014 reveals the hospital has been paid below its hospital-specific DSH limit. Any DSH redistributions resulting from the independent DSH audit in 2014 will be limited to the amount of DSH recouped at that time to ensure DSH payments do not exceed the annual federal DSH allotment. As set forth in the *Federal Register* Volume 73, No. 245/Friday, December 19, 2008, page 77915, "States are not required to make DSH payments to qualifying hospitals in an amount equal to the hospital-specific limit. The hospital-specific limit is not a DSH payment methodology, and States may impose stricter limits on costs that they will consider in determining payment." Page 77920 of the *Federal Register* also states "States do not have the flexibility to broaden or narrow the costs included in calculating the hospital-specific DSH limit, because the universe of costs is defined in the statute. States do have the flexibility to vary the level of DSH payment between individual hospitals as long as the payments are at or below the hospital-specific limit. And States are not required to make DSH payments that cover all costs included in calculating the hospital-specific DSH limit." No changes have been made to the amendment as a result of this comment.

COMMENT #17: A comment was received questioning if MHD will recoup and redistribute DSH payments if the 2014 independent DSH audits determine that a hospital was overpaid.

RESPONSE AND EXPLANATION OF CHANGE: MHD will recoup excess DSH payments if the 2014 independent DSH audit determines that a hospital was overpaid, as is required by federal law. MHD may redistribute DSH payments that have been recouped from hospitals that were overpaid to hospitals that were shown to be under their hospital-specific DSH limit in the 2014 independent DSH audit, up to the federal DSH allotment. The federal share of any DSH payments recouped in excess of the federal DSH allotment must be returned to the federal government. MHD has amended section (7) to provide additional detail to clarify final DSH adjustments.

COMMENT #18: A comment was received indicating nothing in subsection (7)(A) provides for recoupment and either repayment to

the federal government or redistribution to other hospitals as part of the "Final DSH Adjustments." The intent is unclear and should be set forth in the rule.

RESPONSE AND EXPLANATION OF CHANGE: MHD will recoup excess DSH payments if the 2014 independent DSH audit determines that a hospital was overpaid, as is required by federal law. MHD may redistribute DSH payments that have been recouped from hospitals that were overpaid to hospitals that were shown to be under their hospital-specific DSH limit in the 2014 independent DSH audit, up to the federal DSH allotment. The federal share of any DSH payments recouped in excess of the federal DSH allotment must be returned to the federal government. MHD has amended section (7) to provide additional detail to clarify final DSH adjustments.

COMMENT #19: A comment was received indicating the terms "DSH audit standards" and "DSH audits" used in the proposed rule are not defined and are used inappropriately to describe a DSH survey process that applies no audit standards.

RESPONSE AND EXPLANATION OF CHANGE: MHD used the phrase "DSH audit standards" to reference that the DSH survey itself reflects the standards of calculating uncompensated care cost established by the federal DSH rules. States are given considerable flexibility in developing DSH payment methodologies but are limited by the annual DSH allotment and the costs used to determine the hospital-specific DSH limits. The federal DSH rules do not require the state to perform an audit of the data prior to the DSH payments being made. On page 77908 of the December 19, 2008, *Federal Register*, CMS provided a response to a comment stating in part "Typically, States currently rely on unaudited surveys to estimate uncompensated care in eligible hospitals, and this regulation would simply require reconciliation based on statutory cost limits using a more accurate audit methodology." MHD used the phrase "DSH audits" to reference the requirements in the federal DSH rules that an annual independent audit be performed on actual DSH payments and costs three years after the DSH payments are made. MHD has amended section (4) to provide clarification and added section (10) to define annual independent DSH audits.

COMMENT #20: A comment was received indicating the statement in subsection (7)(A) "DSH audits are completed three (3) years following the initial independent DSH audit." appears to mean that the "DSH audits" will be completed six (6) years after the state fiscal year (SFY) ends.

RESPONSE AND EXPLANATION OF CHANGE: MHD amended section (7) to clarify the timing of the final DSH adjustments.

COMMENT #21: A comment was received questioning the differences between the "DSH audits" performed by the MO HealthNet Division and the federally mandated independent audits.

RESPONSE AND EXPLANATION OF CHANGE: MHD does not perform DSH audits, but calculates interim DSH payments and adjustments based on the state DSH survey. The annual independent DSH audits are the annual independent DSH audits required in the federal DSH rules. MHD amended sections (4) and (7) to clarify the DSH audits are the federally-mandated annual independent DSH audits and added section (10) to define the term annual independent DSH audit.

### 13 CSR 70-15.220 Disproportionate Share Hospital Payments

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.*

(1) General Reimbursement Principles.

(D) Section 1923(g) of the Social Security Act (Act) limits the amount of DSH payments states can pay to each hospital and earn FFP. To be in compliance with the Act, DSH payments shall not exceed one hundred percent (100%) of the uncompensated care costs of providing hospital services to Medicaid and uninsured individuals. Hospital-specific DSH limit calculations must comply with the federal DSH rules (42 CFR 447, Subpart E and 42 CFR 455, Subpart D). If the disproportionate share payments exceed the hospital-specific DSH limit, the difference shall be deducted from disproportionate share payments or recouped from future payments.

(4) DSH Payment Adjustments.

(A) Beginning in Medicaid state plan year 2011, DSH payments made to hospitals will be revised based on the results of a 2011 state DSH survey. The revisions based on the 2011 state DSH survey will ensure state fiscal year (SFY) 2011 DSH payments are eligible for FFP through compliance with the federal DSH rules. These revisions are to serve as interim adjustments until the federally-mandated annual independent DSH audits are complete. Annual independent DSH audits are finalized three (3) years following the SFY year-end reflected in the audit. For example, the SFY 2011 DSH audit will be finalized in 2014. The interim adjustments shall be determined as follows:

1. 2011 estimated hospital-specific DSH limits were determined based upon the state's calculations using data provided in the 2011 state DSH survey, SFY 2011 Medicaid supplemental payments maintained by MHD, and data provided in the final 2007 independent DSH audit, if applicable. DSH payments will be limited to the hospital's estimated hospital-specific DSH limit. The state's calculations will be based on 2011 state DSH surveys received by MO HealthNet as of May 31, 2011. However, a corrected survey may be accepted if it is supported by documentation and the state determines the correction is appropriate and has a material impact on the survey results. The state's calculations are set forth below—

A. The 2011 estimated hospital-specific DSH limit is calculated as follows:

(I) 2011 estimated Medicaid net cost from the 2011 state DSH survey.

(II) Less actual SFY 2011 Medicaid supplemental payments.

(III) Equals 2011 estimated Medicaid uncompensated care cost.

(IV) Plus 2011 estimated uninsured uncompensated care cost from the 2011 state DSH survey.

(V) Equals 2011 estimated hospital-specific DSH limit;

B. The total 2011 estimated longfall/shortfall for each hospital is calculated as follows:

(I) 2011 estimated hospital-specific DSH limit.

(II) Less DSH payments paid by MHD during SFY 2011.

(III) Less out-of-state DSH payments received by the hospital during SFY 2011.

(IV) Equals total 2011 estimated longfall/shortfall;

C. The total 2011 estimated hospital DSH liability is an overpayment subject to recoupment which will be the SFY 2011 interim DSH payment adjustment for hospitals with an estimated longfall. The total 2011 estimated hospital DSH liability is the lessor of the:

(I) The 2011 estimated longfall; or

(II) DSH payments paid during SFY 2011;

D. Hospitals that merge their operations under one (1) Medicare and MO HealthNet provider number shall have their SFY 2011 DSH payments adjusted based on combining the results of the 2011 state DSH surveys prorated monthly for the time period the merger was effective. If a 2011 estimated DSH liability is identified, the surviving hospital assumes the responsibility for the overpayment. The calculation for combining and prorating the 2011 state DSH surveys is set forth below—

(I) The estimated hospital DSH liability prior to the merg-

er shall be calculated as follows:

(a) The calculations set forth in subparagraphs (4)(A)1.A., (4)(A)1.B., and (4)(A)1.C. will be calculated based on each separate hospital's 2011 state DSH survey, prorated monthly for the time period prior to the merger;

(II) The estimated hospital DSH liability beginning with the month the merger is effective shall be calculated as follows:

(a) The 2011 state DSH surveys for each hospital shall be added together to yield a combined 2011 state DSH survey and prorated monthly for the time period the merger was effective. The calculations set forth in subparagraphs (4)(A)1.A., (4)(A)1.B., and (4)(A)1.C. will be calculated for the combined 2011 state DSH survey;

(III) The total estimated hospital DSH liability for the merged entity will be the sum of the amounts determined in part (4)(A)1.D.(I) for each hospital plus the combined amount determined in part (4)(A)1.D.(II); and

E. Facilities not providing a 2011 state DSH survey shall have their SFY 2011 DSH payments revised using the most recent hospital-specific information provided to the state by the independent DSH auditor trended to the applicable SFY using the trend factor published in *Health Care Costs* by DRI/McGraw-Hill and listed in 13 CSR 70-15.010. A facility that was not included in the most recent hospital-specific information provided to the state by the independent DSH auditor shall have their entire SFY 2011 DSH payment recouped.

2. DSH payments paid during SFY 2011 that exceed the 2011 estimated hospital-specific DSH limits will be recouped from the hospitals to reduce their payments to their 2011 estimated hospital-specific DSH limit.

3. The amount of SFY 2011 DSH payments to be recouped from a hospital by the MO HealthNet Division will be limited in each state fiscal year to two percent (2%) of the hospital's taxable revenue set forth as follows. For recoupments made during SFY 2012 the recoupment amount will be limited to two percent (2%) of the hospital's SFY 2011 taxable revenue. Any balance remaining to be recouped during SFY 2013 will be limited to two percent (2%) of the hospital's SFY 2012 taxable revenue. Any balance remaining to be recouped will be incorporated in the final DSH adjustment, if applicable. The limitation on recoupment of DSH payments shall only apply to recoupments determined in accordance with section (4). No limitation on the recoupment of DSH payments shall apply if the hospital DSH liability is determined as a result of the final annual independent DSH audit set forth in section (7).

(B) Any payments that are recouped from hospitals as a result of the state's calculation in subsection (4)(A) will be redistributed to hospitals that are shown to have been paid less than their 2011 estimated hospital-specific DSH limits (i.e., estimated shortfall). These redistributions will occur proportionally based on each hospital's 2011 estimated shortfall to the total 2011 estimated shortfall, not to exceed each hospital's 2011 estimated hospital-specific DSH limit.

1. Redistribution payments to hospitals that have been paid less than their 2011 estimated hospital-specific DSH limit must occur after the recoupment of payments made to hospitals that have been paid in excess of their 2011 estimated hospital-specific DSH limits. The state may establish a hospital-specific recoupment plan. However, total industry redistribution payments may not exceed total industry recoupments collected to date.

2. If the Medicaid program's original DSH payments did not fully expend the federal DSH allotment for any plan year, the remaining DSH allotment may be paid to hospitals that are under their estimated hospital-specific DSH limit. These payments will occur proportionally based on each hospital's estimated shortfall to the total estimated shortfall, not to exceed each hospital's estimated hospital-specific DSH limit.

(5) Disproportionate Share Hospital (DSH) Interim Payments.

(A) Beginning with SFY 2012, interim DSH payments shall be

calculated on an annual basis as set forth below.

1. SFY 2012 interim DSH payments will be based on the state's calculations using data provided in the 2011 state DSH survey after applying the trend factor published in *Health Care Costs* by DRI/McGraw-Hill for the current fiscal year, estimated SFY 2012 Medicaid supplemental payments calculated by MHD in accordance with 13 CSR 70-15.010, and data provided in the final 2007 independent DSH audit, if applicable.

2. Beginning with SFY 2013, interim DSH payments will be based on the state's calculations using data provided in the state DSH survey for the applicable SFY, estimated Medicaid supplemental payments calculated by MHD in accordance with 13 CSR 70-15.010 for the applicable SFY, and data provided in the most recent final independent DSH audit, if applicable.

(B) The interim DSH payments will be calculated as follows:

1. The estimated hospital-specific DSH limit is calculated as follows:

A. Estimated Medicaid net cost from the state DSH survey.

B. Less estimated Medicaid supplemental payments calculated by MHD in accordance with 13 CSR 70-15.010.

C. Equals estimated Medicaid uncompensated care cost.

D. Plus estimated uninsured uncompensated care cost from the state DSH survey.

E. Equals estimated hospital-specific DSH limit.

2. The estimated uncompensated care costs potentially eligible for MHD interim DSH payments excludes out-of-state DSH payments and is calculated as follows:

A. Estimated hospital-specific DSH limit.

B. Less estimated out-of-state (OOS) DSH payments.

C. Equals estimated uncompensated care cost (UCC) net of OOS DSH payments.

3. Hospitals determined to have a negative estimated UCC net of OOS DSH payments (payments exceed costs) will not receive interim DSH payments because they are expected to exceed their estimated hospital-specific DSH limit unless they meet the requirement in subsection (5)(C).

4. Qualified DSH hospitals determined to have a positive estimated UCC net of OOS DSH payments (costs exceed payments) and hospitals that meet the requirements of subsection (5)(C) will receive interim DSH payments. The interim DSH payments are subject to the federal DSH allotment and the estimated hospital-specific DSH limits. The interim DSH payments will be calculated as follows:

A. Interim DSH payments to qualified DSH hospitals determined to have a positive estimated UCC net of OOS DSH payments will be calculated as follows:

(I) Up to one-hundred percent (100%) of the available federal DSH allotment will be allocated based on each hospital's positive estimated UCC net of OOS DSH payments to the total positive estimated UCC net of OOS DSH payments; and

(II) The allocated amount will then be reduced by one percent (1%) for hospitals that do not contribute through a plan that is approved by the director of the Department of Health and Senior Services to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) and Patient Safety Initiative; and

B. Interim DSH payments to federally-deemed hospitals are set forth in subsection (5)(C).

(C) Federally-deemed hospitals will receive the nominal DSH payment of five thousand dollars (\$5,000) and the greater of their upper payment limit payment or their estimated interim DSH payment as calculated above in subsection (5)(B). Except for federally-deemed hospitals, hospitals may elect to receive an upper payment limit payment as defined in 13 CSR 70-15.230 in lieu of DSH payments.

(D) Disproportionate share payments will coincide with the semi-monthly claim payment schedule with the exception of the federally-deemed hospitals who will be paid the nominal DSH payment of five thousand dollars (\$5,000) at the end of the SFY.

(E) New facilities will be paid based on the industry average estimated interim DSH payment as determined from subsection (5)(B)

calculated as follows:

1. Hospitals receiving interim DSH payments shall be divided into quartiles based on total beds;

2. DSH payments shall be individually summed by quartile and then divided by the total beds in the quartile to yield an average interim DSH payment per bed; and

3. The number of beds for the new facility shall be multiplied by the average DSH payment per bed.

(F) Facilities not providing a state DSH survey for the applicable SFY will have interim DSH payments calculated using the most recent hospital-specific information provided to the state by the independent DSH auditor trended to the applicable SFY using the trend factor published in *Health Care Costs* by DRI/McGraw-Hill and listed in 13 CSR 70-15.010. A facility that was not included in the most recent hospital-specific information provided to the state by the independent DSH auditor shall not receive DSH payments for that SFY.

(G) Interim DSH Payments for Hospital Mergers.

1. Hospitals that merge prior to the beginning of the SFY. Hospitals that merge their operations under one (1) Medicare and MO HealthNet provider number shall have their interim DSH payment determined based on adding each hospital's state DSH survey to yield a combined state DSH survey and applying the same calculations in subsection (5)(B).

2. Hospitals that merge after the beginning of the SFY. The interim DSH payments that have been determined separately for the hospitals will be added together and paid to the surviving hospital effective with the approval date of the merger.

(H) If the Medicaid program's original interim DSH payments did not fully expend the federal DSH allotment for any plan year, the remaining DSH allotment may be paid to hospitals that are under their estimated hospital-specific DSH limit. These payments will occur proportionally based on each hospital's estimated shortfall to the total estimated shortfall, not to exceed each hospital's estimated hospital-specific DSH limit.

(7) Final DSH Adjustments.

(A) Final DSH adjustments will be made after actual cost data is available and the annual independent DSH audit is completed. Annual independent DSH audits are completed three (3) years following the state fiscal year-end reflected in the audit. For example, final DSH adjustments for SFY 2011 DSH payments will be made following the completion of the annual independent DSH audit in 2014 (SFY 2015).

(B) Final DSH adjustments may result in a recoupment for some hospitals and additional DSH payments for other hospitals based on the results of the annual independent DSH audit as set forth below—

1. Hospital DSH liabilities are overpayments which will be recouped. If the annual independent DSH audit reflects that a facility has a hospital DSH liability, it is an overpayment to the hospital and is subject to recoupment;

2. Any overpayments that are recouped from hospitals as the result of the final DSH adjustment will be redistributed to hospitals that are shown to have a total shortfall. These redistributions will occur proportionally based on each hospital's total shortfall to the total shortfall, not to exceed each hospital-specific DSH limit;

3. Redistribution payments to hospitals that have a total shortfall must occur after the recoupment of hospital DSH liabilities. However, total industry redistribution payments may not exceed total industry recoupments collected to date;

4. If the amount of DSH payments to be recouped as a result of the final DSH adjustment is more than can be redistributed, the entire amount will be recouped, and the federal share will be returned to the federal government; and

5. If the Medicaid program's original interim DSH payments did not fully expend the federal DSH allotment for any plan year, the remaining DSH allotment may be paid to hospitals that are under their hospital-specific DSH limit as determined from the annual independent DSH audit. These payments will occur proportionally based

on each hospital's shortfall to the total shortfall, not to exceed each hospital's hospital-specific DSH limit.

(9) State DSH Survey Reporting Requirements.

(A) Each hospital participating in the MO HealthNet program shall submit a state DSH survey prescribed by the state MO HealthNet agency and must be submitted by December 31st of each year. However, a corrected survey may be accepted if it is supported by documentation and the state determines the correction is appropriate and has a material impact on the survey results. The state DSH survey for each interim DSH payment period shall be completed based on the third prior year Medicare cost report and adjusted for inflationary trends and volume adjustments to the interim DSH payment period. For example, the state DSH survey that will be used to determine SFY 2013 interim DSH payments will be based on the state DSH survey completed using the 2010 Medicare cost report data adjusted by the hospital to 2013.

(10) Definitions.

(A) Annual independent DSH audit. The annual independent DSH audit is the annual independent certified audit of the state DSH payments as required by the federal DSH audit rule 42 CFR 455.301 through 42 CFR 455.304. The annual independent DSH audit also includes the reporting requirements of 42 CFR 447.299. The annual independent DSH audit may also be referred to as the federally-mandated annual independent DSH audit or independent federal DSH audit.

(B) Estimated Medicaid net cost. Estimated Medicaid net cost is the cost of providing inpatient and outpatient hospital services for all Medicaid eligible individuals including dual eligible and managed care participants less payments the hospital received for claims. The estimated Medicaid net cost is determined by using Medicare cost report costing methodologies described in this rule and is calculated using data reported on the the state DSH survey. Depending on the hospital's response to questions fourteen, fifteen, and sixteen of the state DSH survey the source of the Medicaid Out-of-State net cost, Medicaid Organ Acquisition net cost, and Medicaid/Medicare Crossover net cost will either be: the hospital's estimated data, an amount estimated by MHD based on the most recent annual independent DSH audit trended to the SFY the DSH payments relate to, or was determined by the hospital to be insignificant or zero. The estimated Medicaid net cost is the sum of the following estimated data:

1. In-state Medicaid inpatient net cost;
2. In-state Medicaid outpatient net cost;
3. Out-of-state Medicaid inpatient net cost;
4. Out-of-state Medicaid outpatient net cost;
5. Medicaid organ acquisition net cost; and
6. Medicaid/Medicare crossover net cost.

(C) Estimated uninsured net cost. Estimated uninsured net cost is the cost of providing inpatient and outpatient hospital services to individuals with no source of third party reimbursement for the inpatient and outpatient hospital services they receive. If the individual had health insurance, even if the third party insurer did not pay, those services are insured and cannot be included as uninsured costs. The costs are to be calculated using Medicare cost report costing methodologies described in this rule and should not include costs for services that were denied for any reason. The estimated uninsured net cost is calculated as the sum of the following estimated data reported on the state DSH survey.

1. Uninsured inpatient net cost.
2. Uninsured outpatient net cost.

(D) Estimated uninsured uncompensated care cost (UCC). The estimated uninsured uncompensated care cost is the estimated uninsured net cost less uninsured revenues and Section 1011 payments.

(E) Federal DSH allotment. The maximum amount of DSH a state can distribute each year, and receive federal financial participation

(FFP) in the payments in accordance with 42 CFR 447.297 and 42 CFR 447.298.

(F) Hospital DSH liability. The hospital DSH liability is the amount of DSH overpayments subject to recoupment. It is the lessor of the total longfall or the DSH payments paid during the SFY. The source for this calculation is as follows:

1. Actual hospital DSH liability. The actual hospital DSH liability is determined from the final annual independent DSH audit; and

2. Estimated hospital DSH liability. The estimated hospital DSH liability is calculated by the state using data from the state DSH survey, Medicaid supplemental payments, and data provided in the most recent independent DSH audit, if applicable.

(G) Hospital-specific DSH limit. The hospital-specific DSH limit is the sum of the Medicaid uncompensated care cost plus the uninsured uncompensated care cost and is calculated each year. The source for this calculation is as follows:

1. Actual hospital-specific DSH limit. The actual hospital-specific DSH limit is determined from the final annual independent DSH audit; and

2. Estimated hospital-specific DSH limit. The estimated hospital-specific DSH limit is calculated by the state using data from the state DSH survey, Medicaid supplemental payments, and data provided in the most recent independent DSH audit, if applicable.

(H) Institution for Mental Diseases (IMD) DSH allotment. The IMD DSH allotment is a portion of the state-wide DSH allotment and is payable only to IMD hospitals.

(I) Inpatient and outpatient hospital services. For purposes of determining the estimated hospital-specific DSH limit and the actual hospital-specific DSH limit, the inpatient and outpatient hospital services are limited to inpatient and outpatient hospital services included in the approved Missouri Medicaid State Plan.

(J) Longfall. The longfall is the total amount a hospital has been paid (including all DSH payments) in excess of their hospital-specific DSH limit and is considered an overpayment subject to recoupment. The source for this calculation is as follows:

1. Actual longfall. The actual longfall is based on the annual independent DSH audit; and

2. Estimated longfall. The estimated longfall is calculated by the state using data from the state DSH survey, Medicaid supplemental payments, and data provided in the most recent independent DSH audit, if applicable.

(K) Medicaid state plan year. Medicaid state plan year coincides with the twelve (12)-month period for which a state calculates DSH payments. For Missouri, the Medicaid State Plan Year coincides with its state fiscal year (SFY) and is July 1 through June 30.

(L) Medicaid supplemental payments. For purposes of determining estimated hospital-specific DSH limits, the Medicaid supplemental payments include: Direct Medicaid Add-On, Graduate Medical Education (GME), Enhanced GME, Children's Outliers, Trauma Outliers, and any cost settlements. Upper payment limit (UPL) supplemental payments will be included in addition to the above Medicaid supplemental payments for purposes of determining the hospital-specific DSH limit in the annual independent DSH audit. Any supplemental payments made with state only funds are not required to be offset in determining the hospital-specific DSH limit.

(M) Medicare cost reporting methodologies. Medicaid and uninsured costs will be determined utilizing Medicare cost report (form 2552-96) methodologies. If the Medicare 2552-96 is superseded by an alternate Medicare developed cost reporting tool during a Medicaid state plan year, that tool must be used for the Medicaid state plan year. Based on these methodologies, the costs included in the DSH payment calculation will reflect the Medicaid and uninsured portion of total allowable costs from the Medicare cost report. Costs such as the Missouri Medicaid hospital provider tax (federal reimbursement allowance or FRA) are recognized as allowable costs for Medicaid and DSH program purposes and apportioned to Medicaid, uninsured, Medicare, and other payers following the cost finding

principles included in the costs report, applicable instructions, regulations, and governing statutes.

(N) New facility. A new hospital determined in accordance with 13 CSR 70-15.010 without a base year cost.

(O) Out-of-state DSH payments. DSH payments received by a Missouri hospital from a state other than Missouri.

(P) Section 1011 payments. Section 1011 payments are made to a hospital for costs incurred for the provision of specific services to specific aliens to the extent that the provider was not otherwise reimbursed for such services. Because a portion of the Section 1011 payments are made for uncompensated care costs that are also eligible under the hospital-specific DSH limit, a defined portion of the section 1011 payments must be recognized as an amount paid on behalf of those uninsured.

(Q) Shortfall. The shortfall is the hospital-specific DSH limit in excess of the total amount a hospital has been paid (including all DSH payments). The source for this calculation is as follows:

1. Actual shortfall. The actual shortfall is based on the annual independent DSH audit; and

2. Estimated shortfall. The estimated shortfall is calculated by the state using data from the state DSH survey, Medicaid supplemental payments, and data provided in the most recent independent DSH audit, if applicable.

(R) State DSH survey. The state DSH survey was designed to reflect the standards of calculating uncompensated care cost established by the federal DSH rules in determining hospital-specific DSH limits. The DSH survey is also similar to the DSH survey that is utilized by the independent auditor during the annual independent DSH audit performed in accordance with the federally-mandated DSH audit rules. The blank state DSH survey is referred to as the state DSH survey template. The following state DSH survey templates and instructions are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109. This rule does not incorporate any subsequent amendments or additions.

1. Version 1 (9/10), also referred to as the 2011 state DSH survey, was used to calculate the SFY 2011 DSH payment adjustments set forth in section (4) and the SFY 2012 interim DSH payments set forth in section (5).

2. Version 2 (9/11) will be used to calculate interim DSH payments beginning with SFY 2013 as set forth in section (5). The survey shall be referred to as the SFY to which payments will relate. For example, the survey used to determine interim DSH payments for SFY 2013 will be referred to as the 2013 state DSH survey.

(S) Taxable revenue. Taxable revenue is the hospital's total inpatient adjusted net revenues plus outpatient adjusted net revenues determined in accordance with 13 CSR 70-15.110, paragraph (1)(A)13.

(T) Uncompensated care costs (UCC). The uncompensated care costs eligible for consideration in determining the hospital-specific DSH limit are calculated by reducing costs incurred in furnishing inpatient and outpatient hospital services to the Medicaid and uninsured populations, reduced by revenues received under Medicaid (not including DSH payments) and Section 1011 payments. The costs are to be calculated using Medicare cost report costing methodologies described in this rule and should not include costs for services that were denied for any reason. For purposes of this calculation the Medicaid and uninsured populations include:

1. The Medicaid population includes all Medicaid eligible individuals including dual eligible and managed care participants; and

2. The uninsured population includes individuals with no source of third-party reimbursement for the inpatient and outpatient services they receive. If the individual had health insurance, even if the third-party insurer did not pay, those services are insured and cannot be included as uninsured costs.

(U) Uninsured revenues. Payments received on a cash basis that are required to be offset against the uninsured cost to determine the uninsured net cost include any amounts received by the hospital, by

or on behalf of, either self-pay or uninsured individuals during the SFY under audit.

**Title 13—DEPARTMENT OF SOCIAL SERVICES**  
**Division 70—MO HealthNet Division**  
**Chapter 15—Hospital Program**

**ORDER OF RULEMAKING**

By the authority vested in the MO HealthNet Division under sections 208.152, 208.153, and 208.201, RSMo Supp. 2010, the division adopts a rule as follows:

**13 CSR 70-15.230 Supplemental Upper Payment Limit**  
**Methodology is adopted.**

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1624-1625). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 16—RETIREMENT SYSTEMS**  
**Division 10—The Public School Retirement System of**  
**Missouri**  
**Chapter 4—Membership and Creditable Service**

**ORDER OF RULEMAKING**

By the authority vested in the board of trustees under section 169.020, RSMo Supp. 2010, the board of trustees amends a rule as follows:

**16 CSR 10-4.012 Payment for Reinstatement and Credit Purchases**  
**is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2011 (36 MoReg 1852). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 16—RETIREMENT SYSTEMS**  
**Division 10—The Public School Retirement System of**  
**Missouri**  
**Chapter 4—Membership and Creditable Service**

**ORDER OF RULEMAKING**

By the authority vested in the board of trustees under section 169.020, RSMo Supp. 2010, the board of trustees amends a rule as follows:

**16 CSR 10-4.014 Reinstatement and Credit Purchases**  
**is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2011 (36 MoReg 1852-1853). No changes have been made in the text



of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 16—RETIREMENT SYSTEMS**  
**Division 10—The Public School Retirement System of Missouri**  
**Chapter 6—The Public Education Employee Retirement System of Missouri**

**ORDER OF RULEMAKING**

By the authority vested in the board of trustees under section 169.610, RSMo Supp. 2010, the board of trustees amends a rule as follows:

**16 CSR 10-6.040 Membership Service Credit is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2011 (36 MoReg 1853). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 16—RETIREMENT SYSTEMS**  
**Division 10—The Public School Retirement System of Missouri**  
**Chapter 6—The Public Education Employee Retirement System of Missouri**

**ORDER OF RULEMAKING**

By the authority vested in the board of trustees under section 169.610, RSMo Supp. 2010, the board of trustees amends a rule as follows:

**16 CSR 10-6.045 Reinstatement and Credit Purchases is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2011 (36 MoReg 1853–1854). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**  
**Division 73—Missouri Board of Nursing Home Administrators**  
**Chapter 1—Organization and Description of Board**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-1.010 General Organization is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1626). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**  
**Division 73—Missouri Board of Nursing Home Administrators**  
**Chapter 2—General Rules**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-2.010 is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1626–1627). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received three (3) comments on the proposed amendment during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment and eight (8) comments were made.

COMMENT #1: Harvey M. Tettlebaum, attorney on behalf of the Missouri Health Care Association, noted that it is not clear from sections (1) and (8) if the board intends to require owners of facilities or who have an ownership of the facility to provide some management services to a licensed nursing home to be licensed as a “nursing home administrator” or whether the new definitions are merely intended to make clear that someone who is acting as an “administrator” of a nursing home must be licensed irrespective of whether he or she has an ownership interest in the nursing facility, manages the nursing facility in whole or in part, or supervises others who actually administer or manage the nursing facility.

RESPONSE: Sections (1) and (8) define that a licensed administrator is someone licensed by the board to administer, manage, or supervise a licensed long-term care facility, whether that person has an ownership of the facility and/or a person that shares administrative duties with others. No change will be made to the rule as a result of this comment.

COMMENT #2: Denise Clemonds, LeadingAge Missouri, appreciates the board including section (7), the definition of health care or aging-related experience.

RESPONSE: No change will be made to the rule as a result of this comment.

COMMENT #3: Denise Clemonds inquired if the board resolved the issue with the Department of Health and Senior Services, Section for Long Term Care Regulation regarding the RCF II regulation being “frozen” so the new licensure level can be used in the RCF II level of care.

RESPONSE: The Section for Long Term Care Regulation will be



amending 19 CSR 30-86.043 and 19 CSR 30-86.047 to be consistent with the board's proposed amendments. No change will be made to the rule as a result of this comment.

**COMMENT #4:** Tim Blattel, Missouri Assisted Living Association, requested that section (1), Administrator, be changed to a person that is currently licensed by the board as either a nursing home administrator or assisted living administrator who manages or supervises a long term care facility as such term is defined in section 344.010, RSMo.

**RESPONSE:** After considerable study and deliberation, the board concludes that section (1) is appropriate at this time. No change will be made to the rule as a result of this comment.

**COMMENT #5:** Tim Blattel requested that section (2), Clock hour, be changed from sixty (60) minutes to fifty (50) minutes.

**RESPONSE:** After considerable study and deliberation, the board concludes that section (2) is appropriate at this time. No change will be made to the rule as a result of this comment.

**COMMENT #6:** Tim Blattel requested that section (3), Continuing education, be changed to mean post-licensure education to maintain professional competency to practice administration of long-term care facilities, as defined in section 344.010, RSMo.

**RESPONSE AND EXPLANATION OF CHANGE:** The board concurs and will amend the language as suggested.

**COMMENT #7:** Tim Blattel questioned if all the references are necessary in section (5).

**RESPONSE:** The references are required by statute and cannot be changed without changes to the statute. No change will be made to the rule as a result of this comment.

**COMMENT #8:** Tim Blattel noted that section (8) can be deleted if the changes are made to section (1).

**RESPONSE:** After considerable study and deliberation, the board concludes that section (8) is appropriate at this time. No change will be made to the rule as a result of this comment.

**COMMENT #9:** Tim Blattel noted that section (10) can be deleted if the changes are made to section (1). Mr. Blattel noted that if section (10) is not deleted, then the language should be changed to clarify whether all RCFs are required to have a licensed administrator.

**RESPONSE:** After considerable study and deliberation, the board concludes that section (10) is appropriate at this time. No change will be made to the rule as a result of this comment.

**COMMENT #10:** Tim Blattel noted that previous section (5), Experience in health-care administration, was removed.

**RESPONSE AND EXPLANATION OF CHANGE:** After considerable review, the board concludes that the former section (5) definition was inadvertently deleted. Section (5) has been reinstated, renumbered to section (6), and the definitions have been renumbered throughout the rule.

**COMMENT #11:** Tim Blattel requested that "health care" be removed from subsection (11)(B) since the terminology could limit options for administrators to seek education in business management.

**RESPONSE:** After considerable study and deliberation, the board concludes that subsection (11)(B) is appropriate at this time. No change will be made to the rule as a result of this comment.

#### 19 CSR 73-2.010 Definitions

(3) Continuing education means post-licensure education to maintain professional competency to practice administration of long-term care facilities, as defined in section 344.010, RSMo.

(6) Experience in health-care administration shall mean having man-

agement responsibility, which shall include the on-site supervision of at least three (3) staff persons in a licensed long-term care or acute-care facility or a licensed mental health facility, or a department of one of these facilities.

(7) Health care facility shall mean a licensed long-term care facility, licensed acute-care facility, or licensed inpatient mental health facility.

(8) Health care or aging-related experience shall mean full-time equivalency experience in a licensed home health agency, licensed hospice agency, licensed acute-care or long-term care facility, licensed adult day care program, or licensed mental health facility.

(9) Nursing Home Administrator shall mean an administrator, as defined in section (1), that administers, manages, or supervises a long-term care facility, as defined in section 344.010, RSMo.

(10) Resident shall mean a person residing in a long-term care facility, as defined in section 344.010, RSMo.

(11) Residential Care and Assisted Living Administrator shall mean an administrator, as defined in section (1), that administers, manages, or supervises an assisted living facility or residential care facility, as defined in Chapter 198, RSMo. This includes residential care facilities that were licensed as a residential care facility II on or before August 27, 2006, and that continue to meet the licensure standards for a residential care facility II in effect on August 27, 2006.

(12) Training agency shall mean—

(A) An accredited educational institution; or

(B) A statewide or national membership agency, association, professional society or organization in the fields of health care or health care management approved by the board to provide courses of instruction and training.

### Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES Division 73—Missouri Board of Nursing Home Administrators Chapter 2—General Rules

#### ORDER OF RULEMAKING

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

#### 19 CSR 73-2.015 Fees is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1627-1628). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

**SUMMARY OF COMMENTS:** The board received one (1) comment on the proposed amendment during the public comment period.

**COMMENT #1:** Denise Clemonds, LeadingAge Missouri, noted that nothing directly in the rule addresses an increase of fifty dollars (\$50.00) plus five dollars and ninety cents (\$5.90) processing fee as indicated on the fiscal note.

**RESPONSE:** Fiscal notes are prepared when there is a cost greater than five hundred dollars (\$500) whether the rule addresses it or not. No change will be made to the rule as a result of this comment.

**Title 19—DEPARTMENT OF HEALTH AND  
SENIOR SERVICES  
Division 73—Missouri Board of Nursing Home  
Administrators  
Chapter 2—General Rules**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-2.020 Procedures and Requirements for Licensure of  
Nursing Home Administrators is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1629-1630). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

**SUMMARY OF COMMENTS:** The board received one (1) comment on the proposed amendment during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment and two (2) comments were made.

**COMMENT #1:** Denise Clemonds, LeadingAge Missouri, noted nothing directly in the rule addresses the increase of fifty-five dollars (\$55.00) as indicated on the fiscal note.

**RESPONSE:** Fiscal notes are prepared when there is a cost greater than five hundred dollars (\$500) whether the rule addresses it or not. No change will be made to the rule as a result of this comment.

**COMMENT #2:** Tim Blattel, Missouri Assisted Living Association, requested changing the language in paragraph (2)(E)1. to include health care or aging-related experience since section (5) was removed from 19 CSR 73-2.010.

**RESPONSE:** This comment is outside of the purview of the amendment change; however, the board amended 19 CSR 73-2.010 to reinstate section (5). No change will be made to the rule as a result of this comment.

**COMMENT #3:** Cindy Wrigley, Missouri Association of Nursing Home Administrators, requested the board to continue considering experience as a top priority when considering qualifications for approval to sit for the exam.

**RESPONSE:** This comment is outside of the purview of the amendment change; therefore, it cannot be addressed. Additionally, experience is set by statute and cannot be changed without changes to the statute. No change will be made to the rule as a result of this comment.

**Title 19—DEPARTMENT OF HEALTH AND  
SENIOR SERVICES  
Division 73—Missouri Board of Nursing Home  
Administrators  
Chapter 2—General Rules**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board adopts a rule as follows:

19 CSR 73-2.022 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1631-1632). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

**SUMMARY OF COMMENTS:** The board received two (2) comments on the proposed rule during the public comment period. In addition, a public hearing on this proposed rule was held August 4, 2011. At the public hearing, the board staff explained the proposed rule, and six (6) comments were made.

**COMMENT #1:** Denise Clemonds, LeadingAge Missouri, noted that the reference to the rule, 19 CSR 73-2.020(2)(E)1.-2., should read as 19 CSR 73-2.022(2)(E)1.-2. in section (4).

**RESPONSE AND EXPLANATION OF CHANGE:** The board concurs and will make the change.

**COMMENT #2:** Denise Clemonds noted that nothing directly in this rule addresses an increase of fifty dollars (\$50.00) plus a five dollars and ninety cents (\$5.90) processing fee as indicated on the fiscal note.

**RESPONSE:** Fiscal notes are prepared when there is a cost greater than five hundred dollars (\$500) whether the rule addresses it or not. No change will be made to the rule as a result of this comment.

**COMMENT #3:** Tim Blattel, Missouri Assisted Living Association, noted that rather than having separate standards by which an individual's criminal history is evaluated, they suggest copying the requirements as outlined in 19 CSR 30-86 for long-term care facilities.

**RESPONSE:** The standards are set by statute, Chapter 344, RSMo, and cannot be changed without changes to the statute. No change will be made to the rule as a result of this comment.

**COMMENT #4:** Tim Blattel suggested changes to the experience qualification in paragraph (2)(E)1. to add another option in experience qualification of five (5) years hotel or general management experience and successful completion of the required 24-hour course on community-based assessments in assisted living facilities.

**RESPONSE:** After considerable study and deliberation, the board concludes that paragraph (2)(E)1. is appropriate at this time. Additional study of experience and education will be ongoing. No change will be made to the rule as a result of this comment.

**COMMENT #5:** Tim Blattel suggested changes to the experience qualification in subparagraphs (2)(E)2.A. and B. by changing the experience language to "health-care or aging-related experience including management and supervisory responsibility."

**RESPONSE:** After considerable study and deliberation, the board concludes that subparagraphs (2)(E)2.A. and B. are appropriate at this time. Additional study of experience and education will be ongoing. No change will be made to the rule as a result of this comment.

**COMMENT #6:** Tim Blattel suggested changes to section (3) to include applicants that are eligible to take the exams upon board approval and pay the fees if the applicant completed the five (5) criteria in section (2).

**RESPONSE:** After considerable study and deliberation, the board concludes that section (3) is appropriate at this time. No change will be made to the rule as a result of this comment.

**COMMENT #7:** Tim Blattel suggested changes to section (4) to allow the applicant to withdraw the application or submit additional information.

**RESPONSE AND EXPLANATION OF CHANGE:** After considerable study and deliberation, the board concludes that section (4) is appropriate. However, to provide clarification, the board will amend section (4) by reordering subsections (4)(A) and (B).

COMMENT #8: Tim Blattel suggested including another option for applicants that have failed to meet the criteria to successfully complete a one thousand (1,000)-hour internship with an administrator of an assisted living facility.

RESPONSE: The options for applicants are outlined in section (4). The internship criteria are addressed in 19 CSR 73-2.031. No change will be made to the rule as a result of this comment.

#### **19 CSR 73-2.022 Procedures and Requirements for Licensure of Residential Care and Assisted Living Administrators**

(4) If the board determines the applicant has failed to meet one (1) of the criteria outlined in 19 CSR 73-2.022(2)(E)1.-2., the applicant—

(A) May submit additional information for reevaluation if done so no later than two (2) weeks prior to the next board meeting. The applicant will be given notice of the next board meeting date; or

(B) Must complete the course of instruction and training approved by the board pursuant to 19 CSR 73-2.031. The planned curriculum, including a description of each planned course, must be submitted to the board in writing for PRIOR review and approval. Failure to do so within six (6) months following notification of the board's decision will cause reapplication to become necessary for any future consideration.

### **Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**

#### **Division 73—Missouri Board of Nursing Home Administrators**

##### **Chapter 2—General Rules**

#### **ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

19 CSR 73-2.025 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1633-1634). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received three (3) comments on the proposed amendment during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment, and two (2) comments were made.

COMMENT #1: Denise Clemonds, LeadingAge Missouri, requested the language in subsection (2)(E) to remain as is with performance as a licensed administrator for one (1) year instead of three (3) years. RESPONSE: After study and deliberation, the board concludes that subsection (2)(E) is appropriate at this time. Additional study on reciprocity will be ongoing. No change will be made to the rule as a result of this comment.

COMMENT #2: Denise Clemonds noted that section (7) addresses the regulation 19 CSR 73-2.020 and needs to include 19 CSR 73-2.022.

RESPONSE AND EXPLANATION OF CHANGE: The board concurs and will amend the language to include 19 CSR 73-2.022.

COMMENT #3: Denise Clemonds noted that nothing directly in this rule addresses an increase of fifty dollars (\$50.00) plus a five dollars and ninety cents (\$5.90) processing fee as indicated on the fiscal

note.

RESPONSE: Fiscal notes are prepared when there is a cost greater than five hundred dollars (\$500) whether the rule addresses it or not. No change will be made to the rule as a result of this comment.

COMMENT #4: Tim Blattel, Missouri Assisted Living Association, noted rather than having separate standards by which an individual's criminal history is evaluated, they suggest copying the requirements as outlined in 19 CSR 30-86 for long-term care facilities.

RESPONSE: The standards are set by statute and cannot be changed without changes to the statute. No change will be made to the rule as a result of this comment.

COMMENT # 5: Tim Blattel recommended changes to the language in section (7) to include an applicant has the option to withdraw the application or may submit additional information.

RESPONSE: After considerable study and deliberation, the board concludes that section (7) is appropriate at this time. No changes will be made to the rule as a result of this comment.

#### **19 CSR 73-2.025 Licensure by Reciprocity**

(7) If the applicant is unable to meet the requirements of subsection (2)(E) of this rule, but meets all other requirements of section (2), the candidate shall be considered an applicant for initial licensure pursuant to the appropriate rule 19 CSR 73-2.020(2)(E) or 19 CSR 73-2.022(2)(E). If the results of that evaluation show that the applicant meets the criteria, the board shall accept the applicant's passing of the national examination in another state if it was taken within three (3) years of the applicant's submission for licensure in Missouri. The applicant then must meet the requirements of section (6) of this rule by successfully completing and passing the state examination. If the applicant does not meet the criteria, the applicant will be required to complete a prescribed course of instruction and training as outlined in 19 CSR 73-2.031.

### **Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES**

#### **Division 73—Missouri Board of Nursing Home Administrators**

##### **Chapter 2—General Rules**

#### **ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

19 CSR 73-2.031 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1635). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received two (2) comments on the proposed amendment during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment, and three (3) comments were made.

COMMENT #1: Denise Clemonds, LeadingAge Missouri, requested the requirement of beds in subsection (5)(D) be changed from sixty (60) to thirty (30).

RESPONSE AND EXPLANATION OF CHANGE: The board agrees with this and will amend subsection (5)(D). In addition, subsection (5)(C) will be amended to reflect thirty (30) beds for consistency.

COMMENT #2: Denise Clemonds noted in section (10) that the completion of the internship for the residential care and assisted living administrator license should be completed in its entirety in an assisted living facility or residential care facility II with thirty (30) or more beds.

RESPONSE AND EXPLANATION OF CHANGE: The board agrees with this and will amend the language.

COMMENT #3: Tim Blattel, Missouri Assisted Living Association, noted that this rule should only be for the nursing home administrator license and the internship requirements for the residential care and assisted living administrator license should be outlined in 19 CSR 73-2.022.

RESPONSE: After study and deliberation, the board concludes that the proposed language is appropriate at this time. No change will be made to the rule as a result of this comment.

COMMENT #4: Tim Blattel suggested changing “shall” to “may” in section (1).

RESPONSE: After study and deliberation, the board concludes that section (1) is appropriate at this time. No change will be made to the rule as a result of this comment.

COMMENT #5: Tim Blattel suggested removing “duly” in subsection (5)(C) and section (10).

RESPONSE: After study and deliberation, the board concludes that subsection (5)(C) and section (10) are appropriate at this time. No change will be made to the rule as a result of this comment.

#### **19 CSR 73-2.031 Prescribed Course of Instruction and Training**

(5) Internships as required by section (1) shall be under the direct supervision of a licensed administrator approved and designated as a preceptor by the Missouri Board of Nursing Home Administrators. An administrator may be approved and designated as a preceptor for a period of two (2) years, if s/he—

(C) Is currently serving as the administrator of a duly licensed intermediate care facility (ICF), skilled nursing facility (SNF), assisted living facility (ALF), or any Residential Care Facility (RCF) that was licensed as a residential care II on or before August 27, 2006, that continues to meet the licensure standards for a residential care facility II in effect on August 27, 2006, with thirty (30) or more beds;

(D) Is an administrator of an ICF, SNF, ALF, or RCF (as described above) with thirty (30) or more beds, which is in substantial compliance with the rules governing long-term care facilities; and

(10) A portion of an internship for a nursing home administrator applicant may be completed in a duly licensed ALF or RCF (as described above) with thirty (30) or more beds if the intern desires such experience. The residential care and assisted living administrator applicant may complete its entire portion of an internship in a duly licensed ALF or RCF (as described above) with thirty (30) or more beds. The maximum hours of nursing home administrator internship that may be served in such an ALF or RCF (as described above) are designated as follows. Nursing home administrator applicants may complete up to—

**Title 19—DEPARTMENT OF HEALTH AND  
SENIOR SERVICES  
Division 73—Missouri Board of Nursing Home  
Administrators  
Chapter 2—General Rules**

#### **ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under sections 344.040 and 344.070, RSMo Supp. 2010, the board amends a rule as follows:

#### **19 CSR 73-2.050 Renewal of Licenses is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1635–1638). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received one (1) comment on the proposed amendment during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment, and three (3) comments were made.

COMMENT #1: Denise Clemonds, LeadingAge Missouri, noted that nothing in this rule addresses an increase of fifty dollars (\$50.00) plus four dollars and forty-three cents (\$4.43) processing fee for the two (2)-year license and the twenty-five dollar (\$25.00) plus two dollar and twenty-five cents (\$2.25) processing fee for the one (1)-year license as indicated on the fiscal note.

RESPONSE: Fiscal notes are prepared when there is a cost greater than five hundred dollars (\$500) whether the rule addresses it or not. No change will be made to the rule as a result of this comment.

COMMENT #2: Tim Blattel, Missouri Assisted Living Association, recommended changing the forty (40) clock hours to be board-approved or NAB approved in subsection (2)(A).

RESPONSE: The board addressed the approval by NAB in the paragraph (3)(A)3. No change will be made to the rule as a result of this comment.

COMMENT #3: Tim Blattel and Cindy Wrigley, Missouri Association of Nursing Home Administrators, recommended removing the patient care requirement on the clock hours in subsection (2)(A).

RESPONSE: After study and deliberation, the board concludes that subsection (2)(A) is appropriate at this time. Additional study on clock hour requirements will be ongoing. No change will be made to the rule as a result of this comment.

COMMENT #4: Tim Blattel recommended moving the language from subsection (4)(A) requiring the maximum of twenty (20) of the forty (40) clock hours can be online to (2)(A) for clarification.

RESPONSE: After study and deliberation, the board concludes that subsection (4)(A) is appropriate at this time. No change will be made to the rule as a result of this comment.

**Title 19—DEPARTMENT OF HEALTH AND  
SENIOR SERVICES  
Division 73—Missouri Board of Nursing Home  
Administrators  
Chapter 2—General Rules**

#### **ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

#### **19 CSR 73-2.051 Retired Licensure Status is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1639). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND  
SENIOR SERVICES  
Division 73—Missouri Board of Nursing Home  
Administrators**

**Chapter 2—General Rules**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-2.053 Inactive Licensure Status is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1639–1641). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received one (1) comment during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment, and no comments were made.

COMMENT #1: Denise Clemonds, LeadingAge Missouri, noted nothing directly in this rule addresses an increase in the licensing fee plus the processing fee for the inactive license and inactive license renewal.

RESPONSE: Fiscal notes are prepared when there is a cost greater than five hundred dollars (\$500) whether the rule addresses it or not. No change will be made to the rule as a result of this comment.

**Title 19—DEPARTMENT OF HEALTH AND  
SENIOR SERVICES  
Division 73—Missouri Board of Nursing Home  
Administrators**

**Chapter 2—General Rules**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under sections 344.040 and 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-2.055 Renewal of Expired License is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1642–1643). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received one (1) comment during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment, and no comments were made.

COMMENT #1: Denise Clemonds, LeadingAge Missouri, noted nothing directly in this rule addresses an increase of fifty dollars (\$50.00) plus the five dollars and sixteen cents (\$5.16) processing fee for late license renewals.

RESPONSE: Fiscal notes are prepared when there is a cost greater than five hundred dollars (\$500) whether the rule addresses it or not. No change will be made to the rule as a result of this comment.

**Title 19—DEPARTMENT OF HEALTH AND  
SENIOR SERVICES  
Division 73—Missouri Board of Nursing Home  
Administrators**

**Chapter 2—General Rules**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under sections 344.030 and 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-2.070 Examination is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1644–1645). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received one (1) comment during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment, and one (1) comment was made.

COMMENT #1: Denise Clemonds, LeadingAge Missouri, noted nothing directly in this rule addresses an increase of fifty-five dollars (\$55.00).

RESPONSE: Fiscal notes are prepared when there is a cost greater than five hundred dollars (\$500) whether the rule addresses it or not. No change will be made to the rule as a result of this comment.

COMMENT #2: Tim Blattell, Missouri Assisted Living Association, inquired if both exams have one hundred and thirteen (113) questions.

RESPONSE: No, the number one hundred and thirteen (113) referenced in section (6) refers to the passing score for the national examination. No change will be made to the rule as a result of this comment.

**Title 19—DEPARTMENT OF HEALTH AND  
SENIOR SERVICES  
Division 73—Missouri Board of Nursing Home  
Administrators**

**Chapter 2—General Rules**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under sections 344.030 and 344.070, RSMo Supp.

2010, the board amends a rule as follows:

**19 CSR 73-2.080 Temporary Emergency Licenses is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1646). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received no comments during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment, and one (1) comment was made.

COMMENT #1: Tim Blattel, Missouri Assisted Living Association, requested clarification on the date and event identification in subsection (1)(E) and why the change from submitting a copy.

RESPONSE: The date and event identification are the identifiers for the facility's statement of deficiencies document. The facility will be able to reference these identifiers in lieu of mailing a hard copy of the statement of deficiencies document. No change will be made to the rule as a result of this comment.

**Title 19—DEPARTMENT OF HEALTH AND  
SENIOR SERVICES  
Division 73—Missouri Board of Nursing Home  
Administrators  
Chapter 2—General Rules**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-2.085 Public Complaints is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1646-1647). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND  
SENIOR SERVICES  
Division 73—Missouri Board of Nursing Home  
Administrators  
Chapter 2—General Rules**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-2.120 Duplicate License is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1647). No changes have been made in the text of the pro-

posed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 19—DEPARTMENT OF HEALTH AND  
SENIOR SERVICES  
Division 73—Missouri Board of Nursing Home  
Administrators  
Chapter 2—General Rules**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Board of Nursing Home Administrators under section 344.070, RSMo Supp. 2010, the board amends a rule as follows:

**19 CSR 73-2.130 Notice of Change of Address is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 1, 2011 (36 MoReg 1647-1648). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The board received no comments during the public comment period. In addition, a public hearing on this proposed amendment was held August 4, 2011. At the public hearing, the board staff explained the proposed amendment, and one (1) comment was made.

COMMENT #1: Tim Blattel, Missouri Assisted Living Association, recommended changing the language to "may" rather than "shall" in section (1).

RESPONSE: After study and deliberation, the board concludes that section (1) is appropriate at this time. Additional study on change of contact information will be ongoing. No change will be made to the rule as a result of this comment.

**Title 20—DEPARTMENT OF INSURANCE,  
FINANCIAL INSTITUTIONS AND PROFESSIONAL  
REGISTRATION  
Division 2010—Missouri State Board of Accountancy  
Chapter 2—General Rules**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri State Board of Accountancy under sections 326.262, 326.271, 326.277, 326.280, 326.283, 326.286, and 326.289, RSMo Supp. 2010, the board amends a rule as follows:

**20 CSR 2010-2.160 Fees is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2011 (36 MoReg 1854-1857). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 20—DEPARTMENT OF INSURANCE,  
FINANCIAL INSTITUTIONS AND PROFESSIONAL  
REGISTRATION  
Division 2245—Real Estate Appraisers  
Chapter 6—Educational Requirements**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Real Estate Appraisers commission under section 339.509, RSMo 2000, and section 339.517, RSMo Supp. 2010, the commission amends a rule as follows:

20 CSR 2245-6.015 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on July 15, 2011 (36 MoReg 1755–1756). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

**SUMMARY OF COMMENTS:** One (1) comment was received on the proposed amendment as summarized below.

**COMMENT #1:** Upon further review of the amendment, the commission determined that by specifying that the courses listed in paragraph (2)(A)2. can be accepted as on-line qualifying education it would effectively exclude the courses listed in paragraph (2)(B)2. as on-line qualifying education. Consequently, this would allow general real estate appraisers to obtain the courses on-line, while prohibiting residential real estate appraisers to obtain the exact same courses on-line.

**RESPONSE AND EXPLANATION OF CHANGE:** The commission would like to clarify that the courses to be accepted should include those listed in paragraphs (2)(A)2. and (2)(B)2. by adding (2)(B)2. to the amended language.

**20 CSR 2245-6.015 Examination and Education Requirements**

(2) Qualifying Education. The Missouri Real Estate Appraisers Commission does not accept on-line qualifying education with the exception of the courses listed in paragraphs (2)(A)2. and (2)(B)2. and the “Appraisal Subject Matter Electives” as noted below.

**T**his section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs, and other items required to be published in the *Missouri Register* by law.

**Title 7—DEPARTMENT OF TRANSPORTATION  
Division 10—Missouri Highways and  
Transportation Commission  
Chapter 25—Motor Carrier Operations**

**IN ADDITION**

**7 CSR 10-25.010 Skill Performance Evaluation Certificates for Commercial Drivers**

**PUBLIC NOTICE**

Public Notice and Request for Comments on Applications for Issuance of Skill Performance Evaluation Certificates to Intrastate Commercial Drivers with Diabetes Mellitus or Impaired Vision

**SUMMARY:** This notice publishes MoDOT's receipt of applications for the issuance of Skill Performance Evaluation (SPE) Certificates, from individuals who do not meet the physical qualification requirements in the Federal Motor Carrier Safety Regulations for drivers of commercial motor vehicles in Missouri intrastate commerce, because of impaired vision, or an established medical history or clinical diagnosis of diabetes mellitus currently requiring insulin for control. If granted, the SPE Certificates will authorize these individuals to qualify as drivers of commercial motor vehicles (CMVs), in intrastate commerce only, without meeting the vision standard prescribed in 49 CFR 391.41(b)(10), if applicable, or the diabetes standard prescribed in 49 CFR 391.41(b)(3).

**DATES:** Comments must be received at the address stated below, on or before January 3, 2012.

**ADDRESSES:** You may submit comments concerning an applicant, identified by the application number stated below, by any of the following methods:

- *Email:* Kathy.Hatfield@modot.mo.gov
- *Mail:* PO Box 893, Jefferson City, MO 65102-0893
- *Hand Delivery:* 1320 Creek Trail Drive, Jefferson City, MO 65109
- *Instructions:* All comments submitted must include the agency name and application number for this public notice. For detailed instructions on submitting comments, see the Public Participation heading of the Supplementary Information section of this notice. All comments received will be open and available for public inspection and MoDOT may publish those comments by any available means.

**COMMENTS RECEIVED  
BECOME MoDOT PUBLIC RECORD**

- By submitting any comments to MoDOT, the person authorizes MoDOT to publish those comments by any available means.
- *Docket:* For access to the department's file, to read background documents or comments received, 1320 Creek Trail Drive, Jefferson City, MO 65109, between 7:30 a.m. and 4:00 p.m., CT, Monday through Friday, except state holidays.

**FOR FURTHER INFORMATION CONTACT:** Ms. Kathy Hatfield, Motor Carrier Specialist, (573) 522-9001, MoDOT Motor Carrier Services Division, PO Box 893, Jefferson City, MO 65102-0893. Office hours are from 7:30 a.m. to 4:00 p.m., CT, Monday through Friday, except state holidays.

**SUPPLEMENTARY INFORMATION:**

**Public Participation**

If you want us to notify you that we received your comments, please include a self-addressed, stamped envelope or postcard.

**Background**

The individuals listed in this notice have recently filed applications requesting MoDOT to issue SPE Certificates to exempt them from the physical qualification requirements relating to vision in 49 CFR 391.41(b)(10), or to diabetes in 49 CFR 391.41(b)(3), which otherwise apply to drivers of CMVs in Missouri intrastate commerce.

Under section 622.555, RSMo Supp. 2010, MoDOT may issue a Skill Performance Evaluation Certificate, for not more than a two (2)-year period, if it finds that the applicant has the ability, while operating CMVs, to maintain a level of safety that is equivalent to or greater than the driver qualification standards of 49 CFR 391.41. Upon application, MoDOT may renew an exemption upon expiration.

Accordingly, the agency will evaluate the qualifications of each applicant to determine whether issuing a SPE Certificate will comply with the statutory requirements and will achieve the required level of safety. If granted, the SPE Certificate is only applicable to intrastate transportation wholly within Missouri.

**Qualifications of Applicants**

**Application #MP110719029**

Applicant's Name & Age: Melvin Goldstein, 64

Relevant Physical Condition: Mr. Goldstein's best corrected visual acuity is 20/30 Snellen in his right eye and 20/30 Snellen in his left eye. He was diagnosed with insulin treated diabetes mellitus in 1985.

Relevant Driving Experience: Employed for a company located in St. Louis, MO, he currently drives a seven to fifteen (7-15) passenger vehicle and has approximately thirteen (13) years commercial driving experience. Drives personal vehicle(s) daily.

Doctor's Opinion & Date: Following an examination in May 2011, his endocrinologist certified, "In my medical opinion, Mr. Goldstein's diabetes deficiency is stable, he is capable of performing the driving tasks required to operate a commercial motor vehicle, and his condition will not adversely affect his ability to operate a commercial motor vehicle safely."

Traffic Accidents and Violations: No accidents or violations within the past three (3) years.

**Application #MP090424017**

Renewal Applicant's Name & Age: Rodger D. Jarvis, 60

Relevant Physical Condition: Mr. Jarvis's best-corrected visual acuity in his right eye is 20/25 Snellen and in his left eye is 3/200 Snellen. He had cataract surgery as an infant.

Relevant Driving Experience: Mr. Jarvis is currently employed as a driver for a coin company. He has approximately three (3) years of commercial motor vehicle driving experience. He currently has a Class E license. Drives personal vehicle(s) daily.



Doctor's Opinion & Date: Following an examination in August 2011, his optometrist certified, "In my medical opinion, Mr. Jarvis's visual deficiency is stable, he is capable of performing the driving tasks required to operate a commercial motor vehicle, and his condition will not adversely affect his ability to operate a commercial motor vehicle safely."

Traffic Accidents and Violations: No accidents or violations on record.

**Application #MP070323014**

Renewal Applicant's Name & Age: Robert Ogle Jr., 52

Relevant Physical Condition: Mr. Ogle's best-corrected visual acuity in his left eye is 20/20 Snellen and he is blind in his right eye.

Relevant Driving Experience: Mr. Ogle is currently employed with a water company and has been for over thirteen (13) years. Mr. Ogle indicated that he has over fourteen (14) years commercial motor vehicle driving experience. He currently has a Class A driver's license. Drives personal vehicle(s) daily.

Doctor's Opinion & Date: Following an examination in August 2011, his optometrist certified, "In my medical opinion, Mr. Ogle's visual deficiency is stable, he has sufficient vision to perform the driving tasks required to operate a commercial motor vehicle, and his condition will not adversely affect his ability to operate a commercial motor vehicle safely."

Traffic Accidents and Violations: No accidents or violations on record.

**Request for Comments**

The Missouri Department of Transportation, Motor Carrier Services Division, pursuant to section 622.555, RSMo, and rule 7 CSR 10-25.010, requests public comment from all interested persons on the applications for issuance of Skill Performance Evaluation Certificates described in this notice. We will consider all comments received before the close of business on the closing date indicated earlier in this notice.

Issued on: November 1, 2011

*Jan Skouby, Motor Carrier Services Director, Missouri Department of Transportation.*

**Title 19—DEPARTMENT OF HEALTH AND  
SENIOR SERVICES  
Division 60—Missouri Health Facilities Review  
Committee  
Chapter 50—Certificate of Need Program**

**NOTIFICATION OF REVIEW:  
APPLICATION REVIEW SCHEDULE**

The Missouri Health Facilities Review Committee has initiated review of the applications listed below. A decision is tentatively scheduled for January 9, 2012. These applications are available for public inspection at the address shown below.

**Date Filed**

**Project Number:** Project Name  
City (County)  
Cost, Description

**10/25/11**

**#4689 RS:** The Fremont Assisted Living  
Springfield (Greene County)  
\$5,083,767, Establish 72-bed ALF

**10/26/11**

**#4710 HS:** Saint Luke's Cancer Institute, LLC  
Kansas City (Jackson County)  
\$4,324,997, Replace linear accelerator

**10/27/11**

**#4716 HS:** Hedrick Medical Center  
Chillicothe (Livingston County)  
\$35,289,468, Establish 25-bed critical access hospital

**#4721 NS:** Stockton Nursing Home  
Stockton (Polk County)  
\$5,933,820, Replace 75-bed SNF and add 15 SNF beds

**10/28/11**

**#4706 HS:** Landmark Hospital  
Joplin (Newton County)  
\$1,311,000, Add 12 SNF beds

**#4714 HS:** University of Kansas Hospital  
Kansas City (Jackson County)  
\$1,718,680, Acquire MRI unit

**#4715 HS:** St. Clare Health Center  
St. Louis (St. Louis County)  
\$6,300,000, Acquire CyberKnife

**#4720 HS:** St. Mary's Health Center  
Richmond Heights (St. Louis County)  
\$2,970,000, Replace Cardiac Electrophysiology Laboratory

Any person wishing to request a public hearing for the purpose of commenting on these applications must submit a written request to this effect, which must be received by November 28, 2011. All written requests and comments should be sent to—

Chairman  
Missouri Health Facilities Review Committee  
c/o Certificate of Need Program  
3418 Knipp Drive, Suite F  
Post Office Box 570  
Jefferson City, MO 65102

For additional information, contact  
Karla Houchins, (573) 751-6403.

**Title 19—DEPARTMENT OF HEALTH AND  
SENIOR SERVICES  
Division 60—Missouri Health Facilities Review  
Committee  
Chapter 50—Certificate of Need Program**

**NOTIFICATION OF REVIEW:  
APPLICATION REVIEW SCHEDULE**

The Missouri Health Facilities Review Committee has initiated review of the applications listed below. A decision is tentatively scheduled for December 22, 2011. These applications are available for public inspection at the address shown below.

**Date Filed**

**Project Number:** Project Name  
City (County)  
Cost, Description

**11/10/11**

**#4730 NP:** Ambrose Park Residential Care  
Cole Camp (Benton County)  
\$375,000, Long-term Care Expansion of 8 RCF beds

Any person wishing to request a public hearing for the purpose of commenting on these applications must submit a written request to this effect, which must be received by December 9, 2011. All written requests and comments should be sent to—

Chairman  
Missouri Health Facilities Review Committee  
c/o Certificate of Need Program  
3418 Knipp Drive, Suite F  
Post Office Box 570  
Jefferson City, MO 65102

For additional information, contact  
Karla Houchins, (573) 751-6403.

## STATUTORY LIST OF CONTRACTORS BARRED FROM PUBLIC WORKS PROJECTS

The following is a list of contractor(s) who have been prosecuted and convicted of violating the Missouri Prevailing Wage Law, and whose Notice of Conviction has been filed with the Secretary of State pursuant to Section 290.330, RSMo. In addition, this list includes contractor(s) that have agreed to placement on the list maintained by the Secretary of State pursuant to Section 290.330 as a part of the resolution of criminal charges of violating the Missouri Prevailing Wage Law. Under this statute, no public body shall award a contract for public works to any contractor or subcontractor, or simulation thereof, during the time that such contractor or subcontractor's name appears on this state debarment list maintained by the Secretary of State.


### Contractors Convicted of Violations of the Missouri Prevailing Wage Law

<u>Name of Contractor</u>	<u>Name of Officers</u>	<u>Address</u>	<u>Date of Conviction</u>	<u>Debarment Period</u>
Rycoblake Corp. Case No. 0916-CR03145 (Jackson County Cir. Ct.)		4212 SE Saddlebrook Cir Lee's Summit, MO 64082	7/13/11	7/13/11 to 7/13/12

### Contractors Agreeing to Placement on the Public Works Debarment List as Part of an Agreement Relating to Criminal Pleas

<u>Name of Contractor</u>	<u>Name of Officers</u>	<u>Address</u>	<u>Date of Conviction</u>	<u>Debarment Period</u>
Rycoblake Corp.		4212 SE Saddlebrook Cir Lee's Summit, MO 64082		7/13/11 to 12/1/12
Gerald Chevalier		4212 SE Saddlebrook Cir Lee's Summit, MO 64082		7/13/11 to 12/1/12

Dated this 2 day of August 2011.

  
Carla Buschfest, Director

**ADDITION TO STATUTORY LIST OF CONTRACTORS  
BARRED FROM PUBLIC WORKS PROJECTS**

The following is an addition to the list of contractor(s) who have been prosecuted and convicted of violating the Missouri Prevailing Wage Law, and whose Notice of Conviction has been filed with the Secretary of State pursuant to Section 290.330, RSMo. Under this statute, no public body is permitted to award a contract, directly or indirectly, for public works (1) to Mr. Saxon W. Johnson, (2) to any other contractor or subcontractor that is owned, operated or controlled by Mr. Saxon W. Johnson including The Tile Doctor or (3) to any other simulation of Mr. Saxon W. Johnson or of The Tile Doctor for a period of one year, or until September 2, 2012.

<u>Name of Contractor</u>	<u>Name of Officers</u>	<u>Address</u>	<u>Date of Conviction</u>	<u>Debarment Period</u>
Saxon W. Johnson DBA The Tile Doctor Case No. 10CA-CR01318 Cass County Cir. Ct.		10724 Haskins Ct Shawnee Mission, KS 66210	9/2/2011	9/2/2011-9/2/2012

Dated this 13 day of September 2011.

  
Carla Buschjost, Director

**T**he Secretary of State is required by sections 347.141 and 359.481, RSMo 2000, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript by email to [dissolutions@sos.mo.gov](mailto:dissolutions@sos.mo.gov).

**NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY  
TO ALL CREDITORS OF AND CLAIMANTS AGAINST  
AVA C-STORE, LLC**

On October 24, 2011, AVA C-STORE, LLC, a Missouri limited liability company ("Company"), filed its Notice of Winding Up with the Missouri Secretary of State, effective on the filing date.

All persons and organizations must submit to Company, c/o John M. Carnahan III, Carnahan, Evans, Cantwell & Brown, P.C., 2805 S. Ingram Mill, Springfield, Missouri 65804, a written summary of any claims against Company, including: 1) claimant's name, address and telephone number; 2) amount of claim; 3) date(s) claim accrued (or will accrue); 4) brief description of the nature of the debt or the basis for the claim; and 5) if the claim is secured, and if so, the collateral used as security.

Because of the dissolution, any claims against Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the last of filing or publication of this Notice.

**NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY  
TO ALL CREDITORS OF AND CLAIMANTS AGAINST  
NORTH GLENSTONE C-STORE, LLC**

On October 24, 2011, NORTH GLENSTONE C-STORE, LLC, a Missouri limited liability company ("Company"), filed its Notice of Winding Up with the Missouri Secretary of State, effective on the filing date.

All persons and organizations must submit to Company, c/o John M. Carnahan III, Carnahan, Evans, Cantwell & Brown, P.C., 2805 S. Ingram Mill, Springfield, Missouri 65804, a written summary of any claims against Company, including: 1) claimant's name, address and telephone number; 2) amount of claim; 3) date(s) claim accrued (or will accrue); 4) brief description of the nature of the debt or the basis for the claim; and 5) if the claim is secured, and if so, the collateral used as security.

Because of the dissolution, any claims against Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the last of filing or publication of this Notice.

**NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY  
TO ALL CREDITORS OF AND CLAIMANTS AGAINST  
LESLIE D. DAVIS, LLC**

On October 3, 2011, Leslie D. Davis, LLC, a Missouri limited liability company (the "Company") filed its Notice of Winding Up and Articles of Termination with the Missouri Secretary of State, effective on the filing date. Any and all claims against the Company must be submitted in writing to Leslie D. Davis, 5413 Willow Ave., Raytown, MO 64133. Each claim must include (1) the name, address and telephone number of the claimant; (2) the amount claimed; (3) the basis of the claim; (4) the date on which the claim arose; and (5) documentation supporting the claim. All claims against the Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

**NOTICE OF DISSOLUTION AND WINDING UP  
TO ALL CREDITORS OF AND CLAIMANTS AGAINST  
PAUL AND ANN LUX ASSOCIATES, L.P.**

On October 4, 2011, PAUL AND ANN LUX ASSOCIATES, L.P., a Missouri limited partnership, was dissolved upon the filing of a Certificate of Cancellation with the Secretary of State.

Said partnership requests that all persons and organizations who have claims against it present them immediately by letter to: Christopher E. Erblich, Esq., Husch Blackwell LLP, 190 Carondelet Plaza, Suite 600, St. Louis, MO 63105. All claims must include the claimant's name, address and telephone number, the amount, date and basis for the claim.

ANY CLAIMS AGAINST PAUL AND ANN LUX ASSOCIATES, L.P. WILL BE BARRED UNLESS A PROCEEDING TO ENFORCE THE CLAIM IS COMMENCED WITHIN THREE YEARS AFTER THE LAST PUBLICATION DATE OF THE NOTICES AUTHORIZED BY STATUTE.

**NOTICE OF DISSOLUTION AND WINDING UP  
TO ALL CREDITORS OF AND CLAIMANTS AGAINST  
LUX MANAGEMENT, LLC**

On October 12, 2011, LUX MANAGEMENT, LLC, a Missouri limited liability company, filed its Notice of Winding Up with the Missouri Secretary of State.

Said company requests that all persons and organizations who have claims against it present them immediately by letter to: Christopher E. Erblich, Esq., Husch Blackwell LLP, 190 Carondelet Plaza, Suite 600, St. Louis, MO 63105. All claims must include the claimant's name, address and telephone number, the amount, date and basis for the claim.

NOTICE: BECAUSE OF THE WINDING UP OF LUX MANAGEMENT, LLC, ANY CLAIMS AGAINST IT WILL BE BARRED UNLESS A PROCEEDING TO ENFORCE THE CLAIM IS COMMENCED WITHIN THREE YEARS AFTER THE PUBLICATION OF THE THREE NOTICES AUTHORIZED BY STATUTE, WHICHEVER IS PUBLISHED LAST.

# Rule Changes Since Update to Code of State Regulations

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*, citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—30 (2005) and 31 (2006). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
<b>OFFICE OF ADMINISTRATION</b>					
1 CSR 10	State Officials' Salary Compensation Schedule				35 MoReg 1815
1 CSR 10-17.010	Commissioner of Administration		36 MoReg 1596	36 MoReg 2180	
1 CSR 10-17.040	Commissioner of Administration		36 MoReg 1597	36 MoReg 2180	
1 CSR 10-17.050	Commissioner of Administration		36 MoReg 1601	36 MoReg 2180	
1 CSR 30-5.010	Division of Facilities Management, Design and Construction		36 MoReg 1602	36 MoReg 2180	
1 CSR 30-7.010	Division of Facilities Management, Design and Construction		36 MoReg 1604	36 MoReg 2397	
1 CSR 40-1.030	Purchasing and Materials Management		36 MoReg 1609	36 MoReg 2181	
1 CSR 40-1.050	Purchasing and Materials Management		36 MoReg 1609	36 MoReg 2181	
1 CSR 40-1.060	Purchasing and Materials Management		36 MoReg 1614	36 MoReg 2182	
<b>DEPARTMENT OF AGRICULTURE</b>					
2 CSR 30-2.020	Animal Health		36 MoReg 1981		
2 CSR 30-9.010	Animal Health	36 MoReg 1885	36 MoReg 1982		
2 CSR 30-9.020	Animal Health	36 MoReg 1887	36 MoReg 1984		
2 CSR 30-9.030	Animal Health	36 MoReg 1889	36 MoReg 1989		
2 CSR 30-9.040	Animal Health		36 MoReg 1802		
2 CSR 30-9.050	Animal Health		36 MoReg 1803		
2 CSR 30-9.100	Animal Health		36 MoReg 1806		
2 CSR 30-9.110	Animal Health		36 MoReg 1806		
2 CSR 70-45.005	Plant Industries	36 MoReg 2083	36 MoReg 2159		
2 CSR 80-2.190	State Milk Board		36 MoReg 1809	36 MoReg 2398	
2 CSR 90-10	Weights and Measures				36 MoReg 1762
2 CSR 90-10.001	Weights and Measures		36 MoReg 885		
			36 MoReg 1741	This Issue	
2 CSR 90-10.011	Weights and Measures		36 MoReg 885		
			36 MoReg 1741	This Issue	
2 CSR 90-10.012	Weights and Measures		36 MoReg 886		
			36 MoReg 1742	This Issue	
2 CSR 90-10.013	Weights and Measures		36 MoReg 887		
			36 MoReg 1743	This Issue	
2 CSR 90-10.014	Weights and Measures		36 MoReg 889		
			36 MoReg 1745	This Issue	
2 CSR 90-10.015	Weights and Measures		36 MoReg 890		
			36 MoReg 1746	This Issue	
2 CSR 90-10.020	Weights and Measures		36 MoReg 890		
			36 MoReg 1746	This Issue	
2 CSR 90-10.040	Weights and Measures		36 MoReg 891		
			36 MoReg 1747	This Issue	
2 CSR 90-10.060	Weights and Measures		36 MoReg 892R		
			36 MoReg 1748R	This IssueR	
2 CSR 90-10.070	Weights and Measures		36 MoReg 892R		
			36 MoReg 1748R	This IssueR	
2 CSR 90-10.090	Weights and Measures		36 MoReg 892		
			36 MoReg 1748	This Issue	
2 CSR 90-10.120	Weights and Measures		36 MoReg 892		
			36 MoReg 1748	This Issue	
<b>DEPARTMENT OF CONSERVATION</b>					
3 CSR 10-5.205	Conservation Commission		36 MoReg 2159		
3 CSR 10-5.220	Conservation Commission		36 MoReg 2160		
3 CSR 10-6.415	Conservation Commission		36 MoReg 2160		
3 CSR 10-7.410	Conservation Commission		36 MoReg 2161		
3 CSR 10-7.431	Conservation Commission		36 MoReg 2161		
3 CSR 10-7.433	Conservation Commission		36 MoReg 2161		
3 CSR 10-7.440	Conservation Commission		N.A.	36 MoReg 2116	
3 CSR 10-7.455	Conservation Commission		36 MoReg 2161		36 MoReg 676
3 CSR 10-9.110	Conservation Commission		36 MoReg 2162		
3 CSR 10-10.744	Conservation Commission		36 MoReg 2163		
3 CSR 10-11.110	Conservation Commission		36 MoReg 2166		
3 CSR 10-11.115	Conservation Commission		36 MoReg 2166		
3 CSR 10-11.125	Conservation Commission		36 MoReg 2166		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
3 CSR 10-11.130	Conservation Commission		36 MoReg 2167		
3 CSR 10-11.140	Conservation Commission		36 MoReg 2167		
3 CSR 10-11.160	Conservation Commission		36 MoReg 2168		
3 CSR 10-11.165	Conservation Commission		36 MoReg 2168		
3 CSR 10-11.180	Conservation Commission		36 MoReg 2169		
3 CSR 10-11.185	Conservation Commission		36 MoReg 2170		
3 CSR 10-11.186	Conservation Commission		36 MoReg 2171		
3 CSR 10-11.200	Conservation Commission		36 MoReg 2171		
3 CSR 10-11.205	Conservation Commission		36 MoReg 2172		
3 CSR 10-11.215	Conservation Commission		36 MoReg 2172		
3 CSR 10-12.109	Conservation Commission		36 MoReg 2173		
3 CSR 10-12.110	Conservation Commission		36 MoReg 2173		
3 CSR 10-12.115	Conservation Commission		36 MoReg 2174		
3 CSR 10-12.125	Conservation Commission		36 MoReg 2174		
3 CSR 10-12.130	Conservation Commission		36 MoReg 2175		
3 CSR 10-12.135	Conservation Commission		36 MoReg 2175		
3 CSR 10-12.140	Conservation Commission		36 MoReg 2176		
3 CSR 10-12.145	Conservation Commission		36 MoReg 2176		
3 CSR 10-12.150	Conservation Commission		36 MoReg 2177		
<b>DEPARTMENT OF ECONOMIC DEVELOPMENT</b>					
4 CSR 240-4.020	Public Service Commission		36 MoReg 2230		
<b>DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION</b>					
5 CSR 20-100.105	Division of Learning Services		36 MoReg 2087		
5 CSR 20-100.110	Division of Learning Services ( <i>Changed from 5 CSR 50-200.010</i> )				36 MoReg 2120
5 CSR 20-100.120	Division of Learning Services ( <i>Changed from 5 CSR 50-200.050</i> )				36 MoReg 2120
5 CSR 20-100.130	Division of Learning Services ( <i>Changed from 5 CSR 50-321.010</i> )				36 MoReg 2120
5 CSR 20-100.140	Division of Learning Services ( <i>Changed from 5 CSR 50-321.020</i> )				36 MoReg 2120
5 CSR 20-100.160	Division of Learning Services ( <i>Changed from 5 CSR 50-340.050</i> )				36 MoReg 2120
5 CSR 20-100.170	Division of Learning Services ( <i>Changed from 5 CSR 50-345.100</i> )				36 MoReg 2120
5 CSR 20-100.180	Division of Learning Services ( <i>Changed from 5 CSR 50-345.200</i> )				36 MoReg 2120
5 CSR 20-100.190	Division of Learning Services ( <i>Changed from 5 CSR 50-345.300</i> )				36 MoReg 2120
5 CSR 20-100.200	Division of Learning Services ( <i>Changed from 5 CSR 50-350.040</i> )				36 MoReg 2120
5 CSR 20-100.210	Division of Learning Services ( <i>Changed from 5 CSR 50-355.100</i> )				36 MoReg 2120
5 CSR 20-100.220	Division of Learning Services ( <i>Changed from 5 CSR 50-380.020</i> )				36 MoReg 2120
5 CSR 20-100.230	Division of Learning Services ( <i>Changed from 5 CSR 50-500.010</i> )				36 MoReg 2120
5 CSR 20-200.110	Division of Learning Services ( <i>Changed from 5 CSR 60-90.010</i> )				36 MoReg 2121
5 CSR 20-200.120	Division of Learning Services ( <i>Changed from 5 CSR 60-95.010</i> )				36 MoReg 2121
5 CSR 20-200.130	Division of Learning Services ( <i>Changed from 5 CSR 60-95.020</i> )				36 MoReg 2121
5 CSR 20-200.140	Division of Learning Services ( <i>Changed from 5 CSR 60-95.030</i> )				36 MoReg 2121
5 CSR 20-200.150	Division of Learning Services ( <i>Changed from 5 CSR 60-110.010</i> )				36 MoReg 2121
5 CSR 20-200.160	Division of Learning Services ( <i>Changed from 5 CSR 60-120.010</i> )				36 MoReg 2121
5 CSR 20-200.170	Division of Learning Services ( <i>Changed from 5 CSR 60-120.020</i> )				36 MoReg 2121
5 CSR 20-200.180	Division of Learning Services ( <i>Changed from 5 CSR 60-120.050</i> )				36 MoReg 2121
5 CSR 20-200.190	Division of Learning Services ( <i>Changed from 5 CSR 60-120.070</i> )				36 MoReg 2121
5 CSR 20-200.200	Division of Learning Services ( <i>Changed from 5 CSR 50-865.400</i> )				36 MoReg 2121
5 CSR 20-200.210	Division of Learning Services ( <i>Changed from 5 CSR 50-280.010</i> )				36 MoReg 2121
5 CSR 20-200.220	Division of Learning Services ( <i>Changed from 5 CSR 50-300.010</i> )				36 MoReg 2121
5 CSR 20-200.250	Division of Learning Services ( <i>Changed from 5 CSR 50-340.090</i> )				36 MoReg 2121
5 CSR 20-200.260	Division of Learning Services ( <i>Changed from 5 CSR 50-375.100</i> )				36 MoReg 2121
5 CSR 20-200.270	Division of Learning Services ( <i>Changed from 5 CSR 60-120.080</i> )				36 MoReg 2121
5 CSR 20-300.110	Division of Learning Services ( <i>Changed from 5 CSR 70-742.140</i> )				36 MoReg 2121



Rule Number	Agency	Emergency	Proposed	Order	In Addition
5 CSR 20-300.120	Division of Learning Services ( <i>Changed from 5 CSR 70-742.141</i> )				36 MoReg 2122
5 CSR 20-300.130	Division of Learning Services ( <i>Changed from 5 CSR 70-742.165</i> )				36 MoReg 2122
5 CSR 20-300.140	Division of Learning Services ( <i>Changed from 5 CSR 70-742.170</i> )				36 MoReg 2122
5 CSR 20-300.150	Division of Learning Services ( <i>Changed from 5 CSR 70-760.070</i> )				36 MoReg 2122
5 CSR 20-300.160	Division of Learning Services ( <i>Changed from 5 CSR 70-770.010</i> )				36 MoReg 2122
5 CSR 20-300.170	Division of Learning Services ( <i>Changed from 5 CSR 70-770.020</i> )				36 MoReg 2122
5 CSR 20-300.180	Division of Learning Services ( <i>Changed from 5 CSR 70-770.030</i> )				36 MoReg 2122
5 CSR 20-300.190	Division of Learning Services ( <i>Changed from 5 CSR 70-770.040</i> )				36 MoReg 2122
5 CSR 20-300.200	Division of Learning Services ( <i>Changed from 5 CSR 70-770.050</i> )				36 MoReg 2122
5 CSR 20-400.110	Division of Learning Services ( <i>Changed from 5 CSR 80-670.100</i> )				36 MoReg 2122
5 CSR 20-400.120	Division of Learning Services ( <i>Changed from 5 CSR 80-800.020</i> )				36 MoReg 2122
5 CSR 20-400.130	Division of Learning Services ( <i>Changed from 5 CSR 80-800.060</i> )				36 MoReg 2122
5 CSR 20-400.140	Division of Learning Services ( <i>Changed from 5 CSR 80-800.070</i> )				36 MoReg 2122
5 CSR 20-400.150	Division of Learning Services ( <i>Changed from 5 CSR 80-800.200</i> )				36 MoReg 2122
5 CSR 20-400.160	Division of Learning Services ( <i>Changed from 5 CSR 80-800.220</i> )				36 MoReg 2122
5 CSR 20-400.170	Division of Learning Services ( <i>Changed from 5 CSR 80-800.230</i> )				36 MoReg 2122
5 CSR 20-400.180	Division of Learning Services ( <i>Changed from 5 CSR 80-800.260</i> )				36 MoReg 2122
5 CSR 20-400.190	Division of Learning Services ( <i>Changed from 5 CSR 80-800.270</i> )				36 MoReg 2122
5 CSR 20-400.200	Division of Learning Services ( <i>Changed from 5 CSR 80-800.280</i> )				36 MoReg 2122
5 CSR 20-400.210	Division of Learning Services ( <i>Changed from 5 CSR 80-800.285</i> )				36 MoReg 2122
5 CSR 20-400.220	Division of Learning Services ( <i>Changed from 5 CSR 80-800.290</i> )				36 MoReg 2122
5 CSR 20-400.230	Division of Learning Services ( <i>Changed from 5 CSR 80-800.300</i> )				36 MoReg 2122
5 CSR 20-400.240	Division of Learning Services ( <i>Changed from 5 CSR 80-800.310</i> )				36 MoReg 2122
5 CSR 20-400.250	Division of Learning Services ( <i>Changed from 5 CSR 80-800.350</i> )				36 MoReg 2122
5 CSR 20-400.260	Division of Learning Services ( <i>Changed from 5 CSR 80-800.360</i> )				36 MoReg 2122
5 CSR 20-400.270	Division of Learning Services ( <i>Changed from 5 CSR 80-800.370</i> )				36 MoReg 2122
5 CSR 20-400.280	Division of Learning Services ( <i>Changed from 5 CSR 80-800.380</i> )				36 MoReg 2122
5 CSR 20-400.290	Division of Learning Services ( <i>Changed from 5 CSR 80-800.400</i> )				36 MoReg 2122
5 CSR 20-400.300	Division of Learning Services ( <i>Changed from 5 CSR 80-805.015</i> )				36 MoReg 2122
5 CSR 20-400.310	Division of Learning Services ( <i>Changed from 5 CSR 80-805.020</i> )				36 MoReg 2122
5 CSR 20-400.320	Division of Learning Services ( <i>Changed from 5 CSR 80-805.030</i> )				36 MoReg 2122
5 CSR 20-400.330	Division of Learning Services ( <i>Changed from 5 CSR 80-805.040</i> )				36 MoReg 2122
5 CSR 20-400.340	Division of Learning Services ( <i>Changed from 5 CSR 80-850.010</i> )				36 MoReg 2122
5 CSR 20-400.350	Division of Learning Services ( <i>Changed from 5 CSR 80-850.015</i> )				36 MoReg 2122
5 CSR 20-400.360	Division of Learning Services ( <i>Changed from 5 CSR 80-850.025</i> )				36 MoReg 2122
5 CSR 20-400.370	Division of Learning Services ( <i>Changed from 5 CSR 80-850.030</i> )				36 MoReg 2122
5 CSR 20-400.380	Division of Learning Services ( <i>Changed from 5 CSR 80-850.045</i> )				36 MoReg 2122
5 CSR 20-400.390	Division of Learning Services ( <i>Changed from 5 CSR 80-850.050</i> )				36 MoReg 2122
5 CSR 20-400.400	Division of Learning Services ( <i>Changed from 5 CSR 80-850.060</i> )				36 MoReg 2123
5 CSR 20-400.410	Division of Learning Services ( <i>Changed from 5 CSR 80-860.010</i> )				36 MoReg 2123
5 CSR 20-400.420	Division of Learning Services ( <i>Changed from 5 CSR 80-860.050</i> )				36 MoReg 2123

Rule Number	Agency	Emergency	Proposed	Order	In Addition
5 CSR 20-500.110	Division of Learning Services ( <i>Changed from 5 CSR 90-2.011</i> )				36 MoReg 2123
5 CSR 20-500.120	Division of Learning Services ( <i>Changed from 5 CSR 90-4.100</i> )				36 MoReg 2123
5 CSR 20-500.130	Division of Learning Services ( <i>Changed from 5 CSR 90-4.110</i> )				36 MoReg 2123
5 CSR 20-500.140	Division of Learning Services ( <i>Changed from 5 CSR 90-4.120</i> )				36 MoReg 2123
5 CSR 20-500.150	Division of Learning Services ( <i>Changed from 5 CSR 90-4.200</i> )				36 MoReg 2123
5 CSR 20-500.160	Division of Learning Services ( <i>Changed from 5 CSR 90-4.300</i> )				36 MoReg 2123
5 CSR 20-500.170	Division of Learning Services ( <i>Changed from 5 CSR 90-4.400</i> )				36 MoReg 2123
5 CSR 20-500.180	Division of Learning Services ( <i>Changed from 5 CSR 90-4.410</i> )				36 MoReg 2123
5 CSR 20-500.190	Division of Learning Services ( <i>Changed from 5 CSR 90-4.420</i> )				36 MoReg 2123
5 CSR 20-500.200	Division of Learning Services ( <i>Changed from 5 CSR 90-4.430</i> )				36 MoReg 2123
5 CSR 20-500.210	Division of Learning Services ( <i>Changed from 5 CSR 90-5.400</i> )				36 MoReg 2123
5 CSR 20-500.220	Division of Learning Services ( <i>Changed from 5 CSR 90-5.410</i> )				36 MoReg 2123
5 CSR 20-500.230	Division of Learning Services ( <i>Changed from 5 CSR 90-5.420</i> )				36 MoReg 2123
5 CSR 20-500.240	Division of Learning Services ( <i>Changed from 5 CSR 90-5.430</i> )				36 MoReg 2123
5 CSR 20-500.250	Division of Learning Services ( <i>Changed from 5 CSR 90-5.440</i> )				36 MoReg 2123
5 CSR 20-500.260	Division of Learning Services ( <i>Changed from 5 CSR 90-5.450</i> )				36 MoReg 2123
5 CSR 20-500.270	Division of Learning Services ( <i>Changed from 5 CSR 90-5.460</i> )				36 MoReg 2123
5 CSR 20-500.280	Division of Learning Services ( <i>Changed from 5 CSR 90-5.470</i> )				36 MoReg 2123
5 CSR 20-500.290	Division of Learning Services ( <i>Changed from 5 CSR 90-8.010</i> )				36 MoReg 2123
5 CSR 20-500.300	Division of Learning Services ( <i>Changed from 5 CSR 90-50.010</i> )				36 MoReg 2123
5 CSR 20-500.310	Division of Learning Services ( <i>Changed from 5 CSR 60-95.040</i> )				36 MoReg 2121
5 CSR 20-500.320	Division of Learning Services ( <i>Changed from 5 CSR 60-100.010</i> )				36 MoReg 2121
5 CSR 20-500.330	Division of Learning Services ( <i>Changed from 5 CSR 60-100.020</i> )				36 MoReg 2121
5 CSR 20-500.340	Division of Learning Services ( <i>Changed from 5 CSR 60-480.100</i> )				36 MoReg 2121
5 CSR 20-500.350	Division of Learning Services ( <i>Changed from 5 CSR 60-900.030</i> )				36 MoReg 2121
5 CSR 20-500.360	Division of Learning Services ( <i>Changed from 5 CSR 60-900.040</i> )				36 MoReg 2121
5 CSR 20-500.370	Division of Learning Services ( <i>Changed from 5 CSR 60-900.050</i> )				36 MoReg 2121
5 CSR 20-600.110	Division of Learning Services ( <i>Changed from 5 CSR 50-270.010</i> )				36 MoReg 2121
5 CSR 20-600.120	Division of Learning Services ( <i>Changed from 5 CSR 50-340.020</i> )				36 MoReg 2121
5 CSR 30-4	Division of Financial and Administrative Services				36 MoReg 2120
5 CSR 30-260	Division of Financial and Administrative Services				36 MoReg 2120
5 CSR 30-261	Division of Financial and Administrative Services				36 MoReg 2120
5 CSR 30-345	Division of Financial and Administrative Services				36 MoReg 2120
5 CSR 30-345.011	Division of Administrative and Financial Services		36 MoReg 2093R		
5 CSR 30-640	Division of Financial and Administrative Services				36 MoReg 2120
5 CSR 30-660	Division of Financial and Administrative Services				36 MoReg 2120
5 CSR 30-680	Division of Financial and Administrative Services				36 MoReg 2120
5 CSR 50-200.010	Division of School Improvement ( <i>Changed to 5 CSR 20-100.110</i> )				36 MoReg 2120
5 CSR 50-200.050	Division of School Improvement ( <i>Changed to 5 CSR 20-100.120</i> )				36 MoReg 2120
5 CSR 50-270.010	Division of School Improvement ( <i>Changed to 5 CSR 20-600.110</i> )				36 MoReg 2121
5 CSR 50-280.010	Division of School Improvement ( <i>Changed to 5 CSR 20-200.210</i> )				36 MoReg 2121
5 CSR 50-300.010	Division of School Improvement ( <i>Changed to 5 CSR 20-200.220</i> )				36 MoReg 2121
5 CSR 50-321.010	Division of School Improvement ( <i>Changed to 5 CSR 20-100.130</i> )				36 MoReg 2120
5 CSR 50-321.020	Division of School Improvement ( <i>Changed to 5 CSR 20-100.140</i> )				36 MoReg 2120
5 CSR 50-340.018	Division of School Improvement		36 MoReg 2093R		
5 CSR 50-340.019	Division of School Improvement		36 MoReg 2093R		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
5 CSR 50-340.020	Division of School Improvement ( <i>Changed to 5 CSR 20-600.120</i> )				36 MoReg 2121
5 CSR 50-340.021	Division of School Improvement		36 MoReg 2093R		
5 CSR 50-340.022	Division of School Improvement		36 MoReg 2094R		
5 CSR 50-340.030	Division of School Improvement		36 MoReg 2094R		
5 CSR 50-340.050	Division of School Improvement ( <i>Changed to 5 CSR 20-100.160</i> )				36 MoReg 2120
5 CSR 50-340.060	Division of School Improvement		36 MoReg 2094R		
5 CSR 50-340.070	Division of School Improvement		36 MoReg 2094R		
5 CSR 50-340.090	Division of School Improvement ( <i>Changed to 5 CSR 20-200.250</i> )				36 MoReg 2121
5 CSR 50-340.100	Division of School Improvement		36 MoReg 2095R		
5 CSR 50-340.150	Division of School Improvement		36 MoReg 2095R		
5 CSR 50-345.100	Division of School Improvement ( <i>Changed to 5 CSR 20-100.170</i> )				36 MoReg 2120
5 CSR 50-345.200	Division of School Improvement ( <i>Changed to 5 CSR 20-100.180</i> )				36 MoReg 2120
5 CSR 50-345.300	Division of School Improvement ( <i>Changed to 5 CSR 20-100.190</i> )				36 MoReg 2120
5 CSR 50-350.010	Division of School Improvement		36 MoReg 2095R		
5 CSR 50-350.020	Division of School Improvement		36 MoReg 2095R		
5 CSR 50-350.030	Division of School Improvement		36 MoReg 2096R		
5 CSR 50-350.040	Division of School Improvement ( <i>Changed to 5 CSR 20-100.200</i> )				36 MoReg 2120
5 CSR 50-350.050	Division of School Improvement		36 MoReg 2096R		
5 CSR 50-355.100	Division of School Improvement ( <i>Changed to 5 CSR 20-100.210</i> )				36 MoReg 2120
5 CSR 50-375.100	Division of School Improvement ( <i>Changed to 5 CSR 20-200.260</i> )				36 MoReg 2121
5 CSR 50-380.020	Division of School Improvement ( <i>Changed to 5 CSR 20-100.220</i> )				36 MoReg 2120
5 CSR 50-500.010	Division of School Improvement ( <i>Changed to 5 CSR 20-100.230</i> )				36 MoReg 2120
5 CSR 50-865.400	Division of School Improvement ( <i>Changed to 5 CSR 20-200.200</i> )				36 MoReg 2121
5 CSR 60-90.010	Division of Career Education ( <i>Changed to 5 CSR 20-200.110</i> )				36 MoReg 2121
5 CSR 60-95.010	Division of Career Education ( <i>Changed to 5 CSR 20-200.120</i> )				36 MoReg 2121
5 CSR 60-95.020	Division of Career Education ( <i>Changed to 5 CSR 20-200.130</i> )				36 MoReg 2121
5 CSR 60-95.030	Division of Career Education ( <i>Changed to 5 CSR 20-200.140</i> )				36 MoReg 2121
5 CSR 60-95.040	Division of Career Education ( <i>Changed to 5 CSR 20-500.310</i> )				36 MoReg 2121
5 CSR 60-100.010	Division of Career Education ( <i>Changed to 5 CSR 20-500.320</i> )				36 MoReg 2121
5 CSR 60-100.020	Division of Career Education ( <i>Changed to 5 CSR 20-500.330</i> )				36 MoReg 2121
5 CSR 60-110.010	Division of Career Education ( <i>Changed to 5 CSR 20-200.150</i> )				36 MoReg 2121
5 CSR 60-120.010	Division of Career Education ( <i>Changed to 5 CSR 20-200.160</i> )				36 MoReg 2121
5 CSR 60-120.020	Division of Career Education ( <i>Changed to 5 CSR 20-200.170</i> )				36 MoReg 2121
5 CSR 60-120.050	Division of Career Education ( <i>Changed to 5 CSR 20-200.180</i> )				36 MoReg 2121
5 CSR 60-120.070	Division of Career Education ( <i>Changed to 5 CSR 20-200.190</i> )				36 MoReg 2121
5 CSR 60-120.080	Division of Career Education ( <i>Changed to 5 CSR 20-200.270</i> )				36 MoReg 2121
5 CSR 60-480.100	Division of Career Education ( <i>Changed to 5 CSR 20-500.340</i> )				36 MoReg 2121
5 CSR 60-900.030	Division of Career Education ( <i>Changed to 5 CSR 20-500.350</i> )				36 MoReg 2121
5 CSR 60-900.040	Division of Career Education ( <i>Changed to 5 CSR 20-500.360</i> )				36 MoReg 2121
5 CSR 60-900.050	Division of Career Education ( <i>Changed to 5 CSR 20-500.370</i> )				36 MoReg 2121
5 CSR 70-742.140	Special Education ( <i>Changed to 5 CSR 20-300.110</i> )				36 MoReg 2121
5 CSR 70-742.141	Special Education ( <i>Changed to 5 CSR 20-300.120</i> )				36 MoReg 2122
5 CSR 70-742.165	Special Education ( <i>Changed to 5 CSR 20-300.130</i> )				36 MoReg 2122
5 CSR 70-742.170	Special Education ( <i>Changed to 5 CSR 20-300.140</i> )				36 MoReg 2122
5 CSR 70-760.070	Special Education ( <i>Changed to 5 CSR 20-300.150</i> )				36 MoReg 2122

Rule Number	Agency	Emergency	Proposed	Order	In Addition
5 CSR 70-770.010	Special Education ( <i>Changed to 5 CSR 20-300.160</i> )				36 MoReg 2122
5 CSR 70-770.020	Special Education ( <i>Changed to 5 CSR 20-300.170</i> )				36 MoReg 2122
5 CSR 70-770.030	Special Education ( <i>Changed to 5 CSR 20-300.180</i> )				36 MoReg 2122
5 CSR 70-770.040	Special Education ( <i>Changed to 5 CSR 20-300.190</i> )				36 MoReg 2122
5 CSR 70-770.050	Special Education ( <i>Changed to 5 CSR 20-300.200</i> )				36 MoReg 2122
5 CSR 80-670.100	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.110</i> )				36 MoReg 2122
5 CSR 80-800.020	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.120</i> )				36 MoReg 2122
5 CSR 80-800.060	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.130</i> )				36 MoReg 2122
5 CSR 80-800.070	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.140</i> )				36 MoReg 2122
5 CSR 80-800.200	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.150</i> )				36 MoReg 2122
5 CSR 80-800.220	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.160</i> )				36 MoReg 2122
5 CSR 80-800.230	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.170</i> )				36 MoReg 2122
5 CSR 80-800.260	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.180</i> )				36 MoReg 2122
5 CSR 80-800.270	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.190</i> )				36 MoReg 2122
5 CSR 80-800.280	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.200</i> )				36 MoReg 2122
5 CSR 80-800.285	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.210</i> )				36 MoReg 2122
5 CSR 80-800.290	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.220</i> )				36 MoReg 2122
5 CSR 80-800.300	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.230</i> )				36 MoReg 2122
5 CSR 80-800.310	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.240</i> )				36 MoReg 2122
5 CSR 80-800.350	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.250</i> )				36 MoReg 2122
5 CSR 80-800.360	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.260</i> )				36 MoReg 2122
5 CSR 80-800.370	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.270</i> )				36 MoReg 2122
5 CSR 80-800.380	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.280</i> )				36 MoReg 2122
5 CSR 80-800.400	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.290</i> )				36 MoReg 2122
5 CSR 80-805.015	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.300</i> )				36 MoReg 2122
5 CSR 80-805.020	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.310</i> )				36 MoReg 2122
5 CSR 80-805.030	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.320</i> )				36 MoReg 2122
5 CSR 80-805.040	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.330</i> )				36 MoReg 2122
5 CSR 80-850.010	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.340</i> )				36 MoReg 2122
5 CSR 80-850.015	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.350</i> )				36 MoReg 2122
5 CSR 80-850.025	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.360</i> )				36 MoReg 2122
5 CSR 80-850.030	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.370</i> )				36 MoReg 2122
5 CSR 80-850.045	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.380</i> )				36 MoReg 2122
5 CSR 80-850.050	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.390</i> )				36 MoReg 2122
5 CSR 80-850.060	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.400</i> )				36 MoReg 2123
5 CSR 80-860.010	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.410</i> )				36 MoReg 2123
5 CSR 80-860.050	Teacher Quality and Urban Education ( <i>Changed to 5 CSR 20-400.420</i> )				36 MoReg 2123
5 CSR 80-870.010	Teacher Quality and Urban Education		36 MoReg 2096R		
5 CSR 90-2.011	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.110</i> )				36 MoReg 2123
5 CSR 90-4.100	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.120</i> )				36 MoReg 2123

Rule Number	Agency	Emergency	Proposed	Order	In Addition
5 CSR 90-4.110	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.130</i> )				36 MoReg 2123
5 CSR 90-4.120	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.140</i> )				36 MoReg 2123
5 CSR 90-4.200	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.150</i> )				36 MoReg 2123
5 CSR 90-4.300	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.160</i> )				36 MoReg 2123
5 CSR 90-4.400	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.170</i> )				36 MoReg 2123
5 CSR 90-4.410	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.180</i> )				36 MoReg 2123
5 CSR 90-4.420	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.190</i> )				36 MoReg 2123
5 CSR 90-4.430	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.200</i> )				36 MoReg 2123
5 CSR 90-5.400	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.210</i> )				36 MoReg 2123
5 CSR 90-5.410	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.220</i> )				36 MoReg 2123
5 CSR 90-5.420	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.230</i> )				36 MoReg 2123
5 CSR 90-5.430	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.240</i> )				36 MoReg 2123
5 CSR 90-5.440	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.250</i> )				36 MoReg 2123
5 CSR 90-5.450	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.260</i> )				36 MoReg 2123
5 CSR 90-5.460	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.270</i> )				36 MoReg 2123
5 CSR 90-5.470	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.280</i> )				36 MoReg 2123
5 CSR 90-8.010	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.290</i> )				36 MoReg 2123
5 CSR 90-50.010	Vocational Rehabilitation ( <i>Changed to 5 CSR 20-500.300</i> )				36 MoReg 2123
<b>DEPARTMENT OF HIGHER EDUCATION</b>					
6 CSR 10-2.200	Commissioner of Higher Education		36 MoReg 1749	36 MoReg 2292	
6 CSR 10-11.010	Commissioner of Higher Education	36 MoReg 2221	36 MoReg 1894	This Issue	
<b>DEPARTMENT OF TRANSPORTATION</b>					
7 CSR 10-25.010	Missouri Highways and Transportation Commission				36 MoReg 2400 This Issue
<b>DEPARTMENT OF MENTAL HEALTH</b>					
9 CSR 10-5.240	Director, Department of Mental Health		36 MoReg 2369		
9 CSR 10-31.030	Director, Department of Mental Health	36 MoReg 2083	36 MoReg 2097		
<b>DEPARTMENT OF NATURAL RESOURCES</b>					
10 CSR 10-2.385	Air Conservation Commission		This Issue		
10 CSR 10-5.040	Air Conservation Commission		36 MoReg 2232		
10 CSR 10-5.130	Air Conservation Commission		36 MoReg 2233		
10 CSR 10-5.385	Air Conservation Commission		This Issue		
10 CSR 10-5.455	Air Conservation Commission		36 MoReg 2233		
10 CSR 10-5.490	Air Conservation Commission		36 MoReg 2234		
10 CSR 10-6.020	Air Conservation Commission		36 MoReg 2246		
10 CSR 10-6.070	Air Conservation Commission		36 MoReg 1811		
10 CSR 10-6.075	Air Conservation Commission		36 MoReg 1812		
10 CSR 10-6.080	Air Conservation Commission		36 MoReg 1814		
10 CSR 10-6.310	Air Conservation Commission		36 MoReg 2260		
10 CSR 10-6.400	Air Conservation Commission		36 MoReg 2269		
10 CSR 20-6.010	Clean Water Commission	36 MoReg 1892	36 MoReg 1895		
10 CSR 20-6.300	Clean Water Commission		36 MoReg 1909		
10 CSR 20-7.031	Clean Water Commission		This Issue		
10 CSR 20-8.120	Clean Water Commission		36 MoReg 1815		
10 CSR 20-8.300	Clean Water Commission		36 MoReg 1927		
10 CSR 20-10.010	Clean Water Commission ( <i>Changed to 10 CSR 26-2.010</i> )		36 MoReg 1222	36 MoReg 2299	
10 CSR 20-10.011	Clean Water Commission ( <i>Changed to 10 CSR 26-2.011</i> )		36 MoReg 1227	36 MoReg 2300	
10 CSR 20-10.012	Clean Water Commission ( <i>Changed to 10 CSR 26-2.012</i> )		36 MoReg 1227	36 MoReg 2300	
10 CSR 20-10.020	Clean Water Commission ( <i>Changed to 10 CSR 26-2.020</i> )		36 MoReg 1228	36 MoReg 2302	
10 CSR 20-10.021	Clean Water Commission ( <i>Changed to 10 CSR 26-2.021</i> )		36 MoReg 1236	36 MoReg 2303	
10 CSR 20-10.022	Clean Water Commission ( <i>Changed to 10 CSR 26-2.022</i> )		36 MoReg 1240	36 MoReg 2304	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
10 CSR 20-10.030	Clean Water Commission ( <i>Changed to 10 CSR 26-2.030</i> )		36 MoReg 1241	36 MoReg 2305	
10 CSR 20-10.031	Clean Water Commission ( <i>Changed to 10 CSR 26-2.031</i> )		36 MoReg 1241	36 MoReg 2305	
10 CSR 20-10.032	Clean Water Commission ( <i>Changed to 10 CSR 26-2.032</i> )		36 MoReg 1242	36 MoReg 2306	
10 CSR 20-10.033	Clean Water Commission ( <i>Changed to 10 CSR 26-2.033</i> )		36 MoReg 1243	36 MoReg 2307	
10 CSR 20-10.034	Clean Water Commission ( <i>Changed to 10 CSR 26-2.034</i> )		36 MoReg 1249	36 MoReg 2308	
10 CSR 20-10.040	Clean Water Commission ( <i>Changed to 10 CSR 26-2.040</i> )		36 MoReg 1250	36 MoReg 2308	
10 CSR 20-10.041	Clean Water Commission ( <i>Changed to 10 CSR 26-2.041</i> )		36 MoReg 1251	36 MoReg 2309	
10 CSR 20-10.042	Clean Water Commission ( <i>Changed to 10 CSR 26-2.042</i> )		36 MoReg 1255	36 MoReg 2313	
10 CSR 20-10.043	Clean Water Commission ( <i>Changed to 10 CSR 26-2.043</i> )		36 MoReg 1255	36 MoReg 2313	
10 CSR 20-10.044	Clean Water Commission ( <i>Changed to 10 CSR 26-2.044</i> )		36 MoReg 1258	36 MoReg 2313	
10 CSR 20-10.045	Clean Water Commission ( <i>Changed to 10 CSR 26-2.045</i> )		36 MoReg 1258	36 MoReg 2314	
10 CSR 20-10.050	Clean Water Commission ( <i>Changed to 10 CSR 26-2.050</i> )		36 MoReg 1259	36 MoReg 2314	
10 CSR 20-10.051	Clean Water Commission ( <i>Changed to 10 CSR 26-2.051</i> )		36 MoReg 1259	36 MoReg 2315	
10 CSR 20-10.052	Clean Water Commission ( <i>Changed to 10 CSR 26-2.052</i> )		36 MoReg 1260	36 MoReg 2315	
10 CSR 20-10.053	Clean Water Commission ( <i>Changed to 10 CSR 26-2.053</i> )		36 MoReg 1260	36 MoReg 2315	
10 CSR 20-10.060	Clean Water Commission ( <i>Changed to 10 CSR 26-2.070</i> )		36 MoReg 1261	36 MoReg 2317	
10 CSR 20-10.061	Clean Water Commission ( <i>Changed to 10 CSR 26-2.071</i> )		36 MoReg 1261	36 MoReg 2317	
10 CSR 20-10.062	Clean Water Commission ( <i>Changed to 10 CSR 26-2.072</i> )		36 MoReg 1262	36 MoReg 2318	
10 CSR 20-10.063	Clean Water Commission ( <i>Changed to 10 CSR 26-2.074</i> )		36 MoReg 1262	36 MoReg 2318	
10 CSR 20-10.064	Clean Water Commission ( <i>Changed to 10 CSR 26-2.075</i> )		36 MoReg 1263	36 MoReg 2318	
10 CSR 20-10.065	Clean Water Commission ( <i>Changed to 10 CSR 26-2.078</i> )		36 MoReg 1263	36 MoReg 2318	
10 CSR 20-10.066	Clean Water Commission ( <i>Changed to 10 CSR 26-2.082</i> )		36 MoReg 1264	36 MoReg 2319	
10 CSR 20-10.067	Clean Water Commission ( <i>Changed to 10 CSR 26-2.083</i> )		36 MoReg 1264	36 MoReg 2319	
10 CSR 20-10.068	Clean Water Commission ( <i>Changed to 10 CSR 26-2.080</i> )		36 MoReg 1265	36 MoReg 2319	
10 CSR 20-10.070	Clean Water Commission ( <i>Changed to 10 CSR 26-2.060</i> )		36 MoReg 1265	36 MoReg 2315	
10 CSR 20-10.071	Clean Water Commission ( <i>Changed to 10 CSR 26-2.061</i> )		36 MoReg 1272	36 MoReg 2316	
10 CSR 20-10.072	Clean Water Commission ( <i>Changed to 10 CSR 26-2.062</i> )		36 MoReg 1273	36 MoReg 2316	
10 CSR 20-10.073	Clean Water Commission ( <i>Changed to 10 CSR 26-2.063</i> )		36 MoReg 1273	36 MoReg 2317	
10 CSR 20-10.074	Clean Water Commission ( <i>Changed to 10 CSR 26-2.064</i> )		36 MoReg 1274	36 MoReg 2317	
10 CSR 20-11.090	Clean Water Commission ( <i>Changed to 10 CSR 26-3.090</i> )		36 MoReg 1274	36 MoReg 2320	
10 CSR 20-11.091	Clean Water Commission		36 MoReg 1275R	36 MoReg 2292R	
10 CSR 20-11.092	Clean Water Commission ( <i>Changed to 10 CSR 26-3.092</i> )		36 MoReg 1275	36 MoReg 2320	
10 CSR 20-11.093	Clean Water Commission ( <i>Changed to 10 CSR 26-3.093</i> )		36 MoReg 1276	36 MoReg 2320	
10 CSR 20-11.094	Clean Water Commission ( <i>Changed to 10 CSR 26-3.094</i> )		36 MoReg 1276	36 MoReg 2320	
10 CSR 20-11.095	Clean Water Commission ( <i>Changed to 10 CSR 26-3.095</i> )		36 MoReg 1279	36 MoReg 2321	
10 CSR 20-11.096	Clean Water Commission ( <i>Changed to 10 CSR 26-3.096</i> )		36 MoReg 1280	36 MoReg 2321	
10 CSR 20-11.097	Clean Water Commission ( <i>Changed to 10 CSR 26-3.097</i> )		36 MoReg 1283	36 MoReg 2321	
10 CSR 20-11.098	Clean Water Commission ( <i>Changed to 10 CSR 26-3.098</i> )		36 MoReg 1286	36 MoReg 2322	
10 CSR 20-11.099	Clean Water Commission ( <i>Changed to 10 CSR 26-3.099</i> )		36 MoReg 1289	36 MoReg 2322	
10 CSR 20-11.101	Clean Water Commission ( <i>Changed to 10 CSR 26-3.101</i> )		36 MoReg 1291	36 MoReg 2322	
10 CSR 20-11.102	Clean Water Commission ( <i>Changed to 10 CSR 26-3.102</i> )		36 MoReg 1291	36 MoReg 2322	
10 CSR 20-11.103	Clean Water Commission ( <i>Changed to 10 CSR 26-3.103</i> )		36 MoReg 1292	36 MoReg 2323	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
10 CSR 20-11.104	Clean Water Commission ( <i>Changed to 10 CSR 26-3.104</i> )		36 MoReg 1297	36 MoReg 2323	
10 CSR 20-11.105	Clean Water Commission ( <i>Changed to 10 CSR 26-3.105</i> )		36 MoReg 1297	36 MoReg 2323	
10 CSR 20-11.106	Clean Water Commission ( <i>Changed to 10 CSR 26-3.106</i> )		36 MoReg 1298	36 MoReg 2323	
10 CSR 20-11.107	Clean Water Commission ( <i>Changed to 10 CSR 26-3.107</i> )		36 MoReg 1298	36 MoReg 2324	
10 CSR 20-11.108	Clean Water Commission ( <i>Changed to 10 CSR 26-3.108</i> )		36 MoReg 1301	36 MoReg 2324	
10 CSR 20-11.109	Clean Water Commission ( <i>Changed to 10 CSR 26-3.109</i> )		36 MoReg 1303	36 MoReg 2324	
10 CSR 20-11.110	Clean Water Commission ( <i>Changed to 10 CSR 26-3.110</i> )		36 MoReg 1303	36 MoReg 2324	
10 CSR 20-11.111	Clean Water Commission ( <i>Changed to 10 CSR 26-3.111</i> )		36 MoReg 1304	36 MoReg 2325	
10 CSR 20-11.112	Clean Water Commission ( <i>Changed to 10 CSR 26-3.112</i> )		36 MoReg 1304	36 MoReg 2325	
10 CSR 20-11.113	Clean Water Commission ( <i>Changed to 10 CSR 26-3.113</i> )		36 MoReg 1308	36 MoReg 2325	
10 CSR 20-11.114	Clean Water Commission ( <i>Changed to 10 CSR 26-3.114</i> )		36 MoReg 1311	36 MoReg 2325	
10 CSR 20-11.115	Clean Water Commission ( <i>Changed to 10 CSR 26-3.115</i> )		36 MoReg 1318	36 MoReg 2326	
10 CSR 20-13.080	Clean Water Commission ( <i>Changed to 10 CSR 26-4.080</i> )		36 MoReg 1320	36 MoReg 2326	
10 CSR 20-15.010	Clean Water Commission ( <i>Changed to 10 CSR 26-5.010</i> )		36 MoReg 1320	36 MoReg 2326	
10 CSR 20-15.020	Clean Water Commission ( <i>Changed to 10 CSR 26-5.020</i> )		36 MoReg 1321	36 MoReg 2326	
10 CSR 20-15.030	Clean Water Commission ( <i>Changed to 10 CSR 26-5.030</i> )		36 MoReg 1321	36 MoReg 2327	
10 CSR 23-1.050	Division of Geology and Land Survey		36 MoReg 2178		
10 CSR 25-3.260	Hazardous Waste Management Commission		36 MoReg 1322	36 MoReg 2292	
10 CSR 25-4.261	Hazardous Waste Management Commission		36 MoReg 1322	36 MoReg 2293	
10 CSR 25-5.262	Hazardous Waste Management Commission		36 MoReg 1324	36 MoReg 2293	
10 CSR 25-6.263	Hazardous Waste Management Commission		36 MoReg 1325	36 MoReg 2294	
10 CSR 25-7.264	Hazardous Waste Management Commission		36 MoReg 1326	36 MoReg 2295	
10 CSR 25-7.265	Hazardous Waste Management Commission		36 MoReg 1328	36 MoReg 2296	
10 CSR 25-7.266	Hazardous Waste Management Commission		36 MoReg 1329	36 MoReg 2297	
10 CSR 25-7.268	Hazardous Waste Management Commission		36 MoReg 1330	36 MoReg 2297	
10 CSR 25-7.270	Hazardous Waste Management Commission		36 MoReg 1330	36 MoReg 2297	
10 CSR 25-8.124	Hazardous Waste Management Commission		36 MoReg 1331	36 MoReg 2298	
10 CSR 25-11.279	Hazardous Waste Management Commission		36 MoReg 1339	36 MoReg 2298	
10 CSR 25-13.010	Hazardous Waste Management Commission		36 MoReg 1341	36 MoReg 2299	
10 CSR 25-16.273	Hazardous Waste Management Commission		36 MoReg 1342	36 MoReg 2299	
10 CSR 26-1.010	Petroleum and Hazardous Substance Storage Tanks		36 MoReg 1344	36 MoReg 2299	
10 CSR 26-2.010	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-10.010</i> )		36 MoReg 1222	36 MoReg 2299	
10 CSR 26-2.011	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-10.011</i> )		36 MoReg 1227	36 MoReg 2300	
10 CSR 26-2.012	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-10.012</i> )		36 MoReg 1227	36 MoReg 2300	
10 CSR 26-2.019	Petroleum and Hazardous Substance Storage Tanks		36 MoReg 1344	36 MoReg 2301	
10 CSR 26-2.020	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-10.020</i> )		36 MoReg 1228	36 MoReg 2302	
10 CSR 26-2.021	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-10.021</i> )		36 MoReg 1236	36 MoReg 2303	
10 CSR 26-2.022	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-10.022</i> )		36 MoReg 1240	36 MoReg 2304	
10 CSR 26-2.030	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-10.030</i> )		36 MoReg 1241	36 MoReg 2305	
10 CSR 26-2.031	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-10.031</i> )		36 MoReg 1241	36 MoReg 2305	
10 CSR 26-2.032	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-10.032</i> )		36 MoReg 1242	36 MoReg 2306	
10 CSR 26-2.033	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-10.033</i> )		36 MoReg 1243	36 MoReg 2307	
10 CSR 26-2.034	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-10.034</i> )		36 MoReg 1249	36 MoReg 2308	
10 CSR 26-2.040	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-10.040</i> )		36 MoReg 1250	36 MoReg 2308	
10 CSR 26-2.041	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-10.041</i> )		36 MoReg 1251	36 MoReg 2309	
10 CSR 26-2.042	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-10.042</i> )		36 MoReg 1255	36 MoReg 2313	
10 CSR 26-2.043	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-10.043</i> )		36 MoReg 1255	36 MoReg 2313	
10 CSR 26-2.044	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-10.044</i> )		36 MoReg 1258	36 MoReg 2313	
10 CSR 26-2.045	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-10.045</i> )		36 MoReg 1258	36 MoReg 2314	
10 CSR 26-2.050	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-10.050</i> )		36 MoReg 1259	36 MoReg 2314	

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Rule Number	Agency	Emergency	Proposed	Order	In Addition
10 CSR 26-4.080	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-13.080</i> )		36 MoReg 1320	36 MoReg 2326	
10 CSR 26-5.010	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-15.010</i> )		36 MoReg 1320	36 MoReg 2326	
10 CSR 26-5.020	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-15.020</i> )		36 MoReg 1321	36 MoReg 2326	
10 CSR 26-5.030	Petroleum and Hazardous Substance Storage Tanks ( <i>Changed from 10 CSR 20-15.030</i> )		36 MoReg 1321	36 MoReg 2327	
10 CSR 40-5.010	Land Reclamation Commission		36 MoReg 1820		
10 CSR 40-5.020	Land Reclamation Commission		36 MoReg 1826		
10 CSR 60-5.010	Safe Drinking Water Commission		36 MoReg 2374		
10 CSR 60-7.020	Safe Drinking Water Commission		36 MoReg 2375		
10 CSR 60-8.030	Safe Drinking Water Commission		36 MoReg 2380		
10 CSR 60-15.010	Safe Drinking Water Commission		36 MoReg 2380		
10 CSR 60-15.020	Safe Drinking Water Commission		36 MoReg 2381		
10 CSR 60-15.040	Safe Drinking Water Commission		36 MoReg 2384		
10 CSR 60-15.050	Safe Drinking Water Commission		36 MoReg 2384		
10 CSR 60-15.060	Safe Drinking Water Commission		36 MoReg 2385R 36 MoReg 2385		
10 CSR 60-15.070	Safe Drinking Water Commission		36 MoReg 2391		
10 CSR 60-15.080	Safe Drinking Water Commission		36 MoReg 2393		
10 CSR 60-15.090	Safe Drinking Water Commission		36 MoReg 2394		
<b>DEPARTMENT OF PUBLIC SAFETY</b>					
11 CSR 10-11	Adjutant General				36 MoReg 1196 36 MoReg 1485 36 MoReg 1765 36 MoReg 2330
11 CSR 45-1.015	Missouri Gaming Commission		36 MoReg 2270		
11 CSR 45-1.080	Missouri Gaming Commission		36 MoReg 2270		
11 CSR 45-4.020	Missouri Gaming Commission		36 MoReg 1175	36 MoReg 2117	
11 CSR 45-4.200	Missouri Gaming Commission		36 MoReg 1175	36 MoReg 2117	
11 CSR 45-4.500	Missouri Gaming Commission ( <i>Changed to 11 CSR 45-5.400</i> )		36 MoReg 1176	36 MoReg 2118	
11 CSR 45-4.510	Missouri Gaming Commission		36 MoReg 1176R	36 MoReg 2118R	
11 CSR 45-4.520	Missouri Gaming Commission		36 MoReg 1176R	36 MoReg 2118R	
11 CSR 45-4.530	Missouri Gaming Commission ( <i>Changed to 11 CSR 45-5.410</i> )		36 MoReg 1177	36 MoReg 2118	
11 CSR 45-4.540	Missouri Gaming Commission ( <i>Changed to 11 CSR 45-5.420</i> )		36 MoReg 1177	36 MoReg 2118	
11 CSR 45-5.030	Missouri Gaming Commission		36 MoReg 2270		
11 CSR 45-5.065	Missouri Gaming Commission		36 MoReg 2271		
11 CSR 45-5.192	Missouri Gaming Commission		36 MoReg 1178	36 MoReg 2118	
11 CSR 45-5.194	Missouri Gaming Commission		36 MoReg 1615	This Issue	
11 CSR 45-5.200	Missouri Gaming Commission		36 MoReg 1995		
11 CSR 45-5.400	Missouri Gaming Commission ( <i>Changed from 11 CSR 45-4.500</i> )		36 MoReg 1176	36 MoReg 2118	
11 CSR 45-5.410	Missouri Gaming Commission ( <i>Changed from 11 CSR 45-4.530</i> )		36 MoReg 1177	36 MoReg 2118	
11 CSR 45-5.420	Missouri Gaming Commission ( <i>Changed from 11 CSR 45-4.540</i> )		36 MoReg 1177	36 MoReg 2118	
11 CSR 45-7.160	Missouri Gaming Commission		36 MoReg 2097		
11 CSR 45-9.108	Missouri Gaming Commission		This Issue		
11 CSR 45-9.114	Missouri Gaming Commission		36 MoReg 2098		
11 CSR 45-9.117	Missouri Gaming Commission		36 MoReg 2098		
11 CSR 45-12.090	Missouri Gaming Commission		36 MoReg 2271		
11 CSR 45-17.010	Missouri Gaming Commission		36 MoReg 2099		
11 CSR 45-17.020	Missouri Gaming Commission		36 MoReg 2100		
11 CSR 45-17.030	Missouri Gaming Commission		36 MoReg 2101		
11 CSR 45-17.040	Missouri Gaming Commission		36 MoReg 2101		
11 CSR 45-17.050	Missouri Gaming Commission		36 MoReg 2102R		
11 CSR 45-17.060	Missouri Gaming Commission		36 MoReg 2102		
11 CSR 45-17.070	Missouri Gaming Commission		36 MoReg 2103		
<b>DEPARTMENT OF REVENUE</b>					
12 CSR 10-3.894	Director of Revenue		36 MoReg 1995R		
12 CSR 10-4.628	Director of Revenue		36 MoReg 1995R		
12 CSR 10-23.070	Director of Revenue		36 MoReg 2103R		
12 CSR 10-41.010	Director of Revenue	This Issue	This Issue		
12 CSR 10-43.030	Director of Revenue		36 MoReg 2395		
<b>DEPARTMENT OF SOCIAL SERVICES</b>					
13 CSR 70-3.210	MO HealthNet Division		36 MoReg 1828	36 MoReg 2399	
13 CSR 70-3.220	MO HealthNet Division		36 MoReg 1829	36 MoReg 2399	
13 CSR 70-10.016	MO HealthNet Division	36 MoReg 2222	36 MoReg 1832	36 MoReg 2399	
13 CSR 70-10.030	MO HealthNet Division	36 MoReg 2224	36 MoReg 2272		36 MoReg 2401
13 CSR 70-10.110	MO HealthNet Division	36 MoReg 2225	36 MoReg 1835	36 MoReg 2399	
13 CSR 70-15.010	MO HealthNet Division	36 MoReg 1575	36 MoReg 1616	This Issue	
13 CSR 70-15.110	MO HealthNet Division	36 MoReg 2226	36 MoReg 1840	This Issue	
13 CSR 70-15.160	MO HealthNet Division	36 MoReg 2227	36 MoReg 1843		
13 CSR 70-15.220	MO HealthNet Division	36 MoReg 1577	36 MoReg 1620	This Issue	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
13 CSR 70-15.230	MO HealthNet Division	36 MoReg 1580	36 MoReg 1624	This Issue	
13 CSR 70-20.320	MO HealthNet Division	35 MoReg 1072	35 MoReg 1114		
13 CSR 70-26.010	MO HealthNet Division		36 MoReg 1846	36 MoReg 2399	
13 CSR 70-35.010	MO HealthNet Division		36 MoReg 2273		
<b>DEPARTMENT OF CORRECTIONS</b>					
14 CSR 80-3.010	State Board of Probation and Parole		This Issue		
14 CSR 80-3.020	State Board of Probation and Parole		This Issue		
14 CSR 80-5.010	State Board of Probation and Parole		This Issue		
14 CSR 80-5.020	State Board of Probation and Parole		This Issue		
<b>ELECTED OFFICIALS</b>					
15 CSR 30-200.010	Secretary of State		This Issue		
15 CSR 30-200.020	Secretary of State		This Issue		
15 CSR 60-13.060	Attorney General		36 MoReg 2274		
<b>RETIREMENT SYSTEMS</b>					
16 CSR 10-4.012	The Public School Retirement System of Missouri		36 MoReg 1852	This Issue	
16 CSR 10-4.014	The Public School Retirement System of Missouri		36 MoReg 1852	This Issue	
16 CSR 10-6.040	The Public School Retirement System of Missouri		36 MoReg 1853	This Issue	
16 CSR 10-6.045	The Public School Retirement System of Missouri		36 MoReg 1853	This Issue	
16 CSR 20-2.085	Missouri Local Government Employees' Retirement System (LAGERS)		36 MoReg 2275		
16 CSR 20-4.010	Missouri Local Government Employees' Retirement System (LAGERS)		36 MoReg 2276		
16 CSR 50-2.035	The County Employees' Retirement Fund		36 MoReg 2103		
<b>DEPARTMENT OF HEALTH AND SENIOR SERVICES</b>					
19 CSR 10-10	Office of the Director				36 MoReg 1700
19 CSR 30-1	Division of Regulation and Licensure				36 MoReg 1702
19 CSR 30-1.015	Division of Regulation and Licensure		36 MoReg 1451	36 MoReg 2182	
19 CSR 30-1.017	Division of Regulation and Licensure		36 MoReg 1455	36 MoReg 2183	
19 CSR 30-1.019	Division of Regulation and Licensure		36 MoReg 1463	36 MoReg 2186	
19 CSR 30-1.023	Division of Regulation and Licensure		36 MoReg 1463	36 MoReg 2187	
19 CSR 30-1.066	Division of Regulation and Licensure		36 MoReg 1464	36 MoReg 2188	
19 CSR 30-20	Division of Regulation and Licensure				36 MoReg 1704
19 CSR 30-20.097	Division of Regulation and Licensure		36 MoReg 1464	36 MoReg 2188	
19 CSR 60-50	Missouri Health Facilities Review Committee				36 MoReg 2334 This Issue
19 CSR 73	Missouri Board of Nursing Home Administrators				36 MoReg 1707
19 CSR 73-1.010	Missouri Board of Nursing Home Administrators		36 MoReg 1520 36 MoReg 1626	This Issue	
19 CSR 73-2.010	Missouri Board of Nursing Home Administrators	36 MoReg 1515	36 MoReg 1520 36 MoReg 1626	This Issue	
19 CSR 73-2.015	Missouri Board of Nursing Home Administrators		36 MoReg 1521 36 MoReg 1627	This Issue	
19 CSR 73-2.020	Missouri Board of Nursing Home Administrators	36 MoReg 1516	36 MoReg 1524 36 MoReg 1629	This Issue	
19 CSR 73-2.022	Missouri Board of Nursing Home Administrators	36 MoReg 1517	36 MoReg 1526 36 MoReg 1631	This Issue	
19 CSR 73-2.025	Missouri Board of Nursing Home Administrators	36 MoReg 1518	36 MoReg 1528 36 MoReg 1633	This Issue	
19 CSR 73-2.031	Missouri Board of Nursing Home Administrators		36 MoReg 1530 36 MoReg 1635	This Issue	
19 CSR 73-2.050	Missouri Board of Nursing Home Administrators		36 MoReg 1530 36 MoReg 1635	This Issue	
19 CSR 73-2.051	Missouri Board of Nursing Home Administrators		36 MoReg 1534 36 MoReg 1639	This Issue	
19 CSR 73-2.053	Missouri Board of Nursing Home Administrators		36 MoReg 1534 36 MoReg 1639	This Issue	
19 CSR 73-2.055	Missouri Board of Nursing Home Administrators		36 MoReg 1537 36 MoReg 1642	This Issue	
19 CSR 73-2.070	Missouri Board of Nursing Home Administrators	36 MoReg 1519	36 MoReg 1539 36 MoReg 1644	This Issue	
19 CSR 73-2.080	Missouri Board of Nursing Home Administrators		36 MoReg 1541 36 MoReg 1646	This Issue	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
19 CSR 73-2.085	Missouri Board of Nursing Home Administrators		36 MoReg 1541 36 MoReg 1646	This Issue	
19 CSR 73-2.120	Missouri Board of Nursing Home Administrators		36 MoReg 1542 36 MoReg 1647	This Issue	
19 CSR 73-2.130	Missouri Board of Nursing Home Administrators		36 MoReg 1542 36 MoReg 1647	This Issue	
<b>DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION</b>					
20 CSR	Construction Claims Binding Arbitration Cap				35 MoReg 654 36 MoReg 192
20 CSR	Sovereign Immunity Limits				35 MoReg 318
20 CSR	State Legal Expense Fund Cap				35 MoReg 654 36 MoReg 192
20 CSR 1100-2.040	Division of Credit Unions		36 MoReg 2104		
20 CSR 1100-2.055	Division of Credit Unions		36 MoReg 2105		
20 CSR 1100-2.075	Division of Credit Unions		36 MoReg 2105		
20 CSR 1100-2.240	Division of Credit Unions		36 MoReg 2106		
20 CSR 2010-2.160	Missouri State Board of Accountancy	36 MoReg 1795	36 MoReg 1855	This Issue	
20 CSR 2015-1.030	Acupuncturist Advisory Committee	36 MoReg 1173	36 MoReg 1179	36 MoReg 1939	
20 CSR 2030-2.040	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		This Issue		
20 CSR 2030-2.050	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		This Issue		
20 CSR 2030-11.015	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		This Issue		
20 CSR 2030-11.035	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		This Issue		
20 CSR 2030-14.050	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		This IssueR		
20 CSR 2095-1.020	Committee for Professional Counselors	36 MoReg 1173	36 MoReg 1182	36 MoReg 1939	
20 CSR 2150-2.004	State Board of Registration for the Healing Arts		36 MoReg 2281		
20 CSR 2150-2.005	State Board of Registration for the Healing Arts		36 MoReg 2281		
20 CSR 2150-2.015	State Board of Registration for the Healing Arts		36 MoReg 2282R 36 MoReg 2282		
20 CSR 2150-2.020	State Board of Registration for the Healing Arts		36 MoReg 2287R		
20 CSR 2150-2.030	State Board of Registration for the Healing Arts		36 MoReg 2287		
20 CSR 2150-2.035	State Board of Registration for the Healing Arts		36 MoReg 2290		
20 CSR 2150-2.100	State Board of Registration for the Healing Arts		36 MoReg 2291		
20 CSR 2150-2.150	State Board of Registration for the Healing Arts		This Issue		
20 CSR 2150-3.010	State Board of Registration for the Healing Arts		This Issue		
20 CSR 2150-6.010	State Board of Registration for the Healing Arts		This Issue		
20 CSR 2150-6.020	State Board of Registration for the Healing Arts		This Issue		
20 CSR 2150-6.040	State Board of Registration for the Healing Arts		This Issue		
20 CSR 2150-6.062	State Board of Registration for the Healing Arts		This Issue		
20 CSR 2220-2.675	State Board of Pharmacy	36 MoReg 2084	36 MoReg 2107		
20 CSR 2245-1.010	Real Estate Appraisers		36 MoReg 1752	36 MoReg 2327	
20 CSR 2245-3.010	Real Estate Appraisers		36 MoReg 1752	36 MoReg 2327	
20 CSR 2245-4.025	Real Estate Appraisers		36 MoReg 1753	36 MoReg 2328	
20 CSR 2245-6.015	Real Estate Appraisers		36 MoReg 1755	This Issue	
20 CSR 2245-6.040	Real Estate Appraisers		36 MoReg 1756	36 MoReg 2328	
20 CSR 2245-8.010	Real Estate Appraisers		36 MoReg 1756	36 MoReg 2328	
20 CSR 2245-8.030	Real Estate Appraisers		36 MoReg 1756	36 MoReg 2328	
20 CSR 2250-4.070	Missouri Real Estate Commission		This Issue		
20 CSR 2250-7.070	Missouri Real Estate Commission		This Issue		
20 CSR 2250-8.030	Missouri Real Estate Commission		This Issue		
20 CSR 2250-8.120	Missouri Real Estate Commission		This Issue		
<b>MISSOURI CONSOLIDATED HEALTH CARE PLAN</b>					
22 CSR 10-1.010	Health Care Plan		This Issue		
22 CSR 10-1.020	Health Care Plan		This Issue		
22 CSR 10-2.010	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.020	Health Care Plan	This IssueR	This IssueR		
		This Issue	This Issue		
22 CSR 10-2.030	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.045	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.051	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.052	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.053	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.054	Health Care Plan		This Issue		
22 CSR 10-2.055	Health Care Plan	This IssueR	This IssueR		
		This Issue	This Issue		
22 CSR 10-2.060	Health Care Plan		This Issue		
22 CSR 10-2.070	Health Care Plan		This Issue		
22 CSR 10-2.075	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.090	Health Care Plan	This Issue	This Issue		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
22 CSR 10-2.091	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.092	Health Care Plan		This IssueR		
			This Issue		
22 CSR 10-2.093	Health Care Plan		This IssueR		
			This Issue		
22 CSR 10-2.094	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.095	Health Care Plan	This Issue	This Issue		
22 CSR 10-2.100	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.010	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.020	Health Care Plan	This IssueR	This IssueR		
		This Issue	This Issue		
22 CSR 10-3.030	Health Care Plan		This Issue		
22 CSR 10-3.045	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.053	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.054	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.055	Health Care Plan		This Issue		
22 CSR 10-3.056	Health Care Plan		This Issue		
22 CSR 10-3.057	Health Care Plan	This IssueR	This IssueR		
		This Issue	This Issue		
22 CSR 10-3.060	Health Care Plan		This Issue		
22 CSR 10-3.070	Health Care Plan		This Issue		
22 CSR 10-3.075	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.090	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.092	Health Care Plan		This IssueR		
			This Issue		
22 CSR 10-3.093	Health Care Plan		This IssueR		
			This Issue		
22 CSR 10-3.100	Health Care Plan	This Issue	This Issue		

# Emergency Rule Table

Agency	Publication	Effective	Expiration
<b>Department of Agriculture</b>			
<b>Animal Health</b>			
2 CSR 30-9.010	Animal Care Facilities Definitions . . . . .	.36 MoReg 1885 . . . . .	July 21, 2011 . . . . .Feb. 23, 2012
2 CSR 30-9.020	Animal Care Facility Rules Governing Licensing, Fees, Reports, Record Keeping, Veterinary Care, Identification, and Holding Period . . . . .	.36 MoReg 1887 . . . . .	July 21, 2011 . . . . .Feb. 23, 2012
2 CSR 30-9.030	Animal Care Facilities Minimum Standards of Operation and Transportation . . . . .	.36 MoReg 1889 . . . . .	July 21, 2011 . . . . .Feb. 23, 2012
<b>Plant Industries</b>			
2 CSR 70-45.005	Noxious Weed List . . . . .	.36 MoReg 2083 . . . . .	Aug. 28, 2011 . . . . .Feb. 23, 2012
<b>Department of Higher Education</b>			
<b>Commissioner of Higher Education</b>			
6 CSR 10-11.010	Nursing Education Incentive Program . . . . .	.36 MoReg 2221 . . . . .	Oct. 3, 2011 . . . . .March 30, 2012
<b>Department of Mental Health</b>			
<b>Director, Department of Mental Health</b>			
9 CSR 10-31.030	Intermediate Care Facility for the Mentally Retarded Federal Reimbursement Allowance . . . . .	.36 MoReg 2083 . . . . .	Oct. 1, 2011 . . . . .March 28, 2012
<b>Department of Natural Resources</b>			
<b>Clean Water Commission</b>			
10 CSR 20-6.010	Construction and Operating Permits . . . . .	.36 MoReg 1892 . . . . .	Oct. 31, 2011 . . . . .April 27, 2012
<b>Department of Revenue</b>			
<b>Director of Revenue</b>			
12 CSR 10-41.010	Annual Adjusted Rate of Interest . . . . .	This Issue . . . . .	Jan. 1, 2012 . . . . .June 28, 2012
<b>Department of Social Services</b>			
<b>MO HealthNet Division</b>			
13 CSR 70-10.016	Global Per Diem Adjustments to Nursing Facility and HIV Nursing Facility Reimbursement Rates . . . . .	.36 MoReg 2222 . . . . .	Oct. 1, 2011 . . . . .March 28, 2012
13 CSR 70-10.030	Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/MR Services . . . . .	.36 MoReg 2224 . . . . .	Oct. 1, 2011 . . . . .March 28, 2012
13 CSR 70-10.110	Nursing Facility Reimbursement Allowance . . . . .	.36 MoReg 2225 . . . . .	Oct. 1, 2011 . . . . .March 28, 2012
13 CSR 70-15.110	Federal Reimbursement Allowance (FRA) . . . . .	.36 MoReg 2226 . . . . .	Oct. 1, 2011 . . . . .March 28, 2012
13 CSR 70-15.160	Prospective Outpatient Hospital Services Reimbursement Methodology . . . . .	.36 MoReg 2227 . . . . .	Oct. 1, 2011 . . . . .March 28, 2012
13 CSR 70-15.230	Supplemental Upper Payment Limit Methodology . . . . .	.36 MoReg 1580 . . . . .	July 1, 2011 . . . . .Dec. 28, 2011
<b>Department of Health and Senior Services</b>			
<b>Missouri Board of Nursing Home Administrators</b>			
19 CSR 73-2.010	Definitions . . . . .	.36 MoReg 1515 . . . . .	May 15, 2011 . . . . .Feb. 23, 2012
19 CSR 73-2.020	Procedures and Requirements for Licensure of Nursing Home Administrators . . . . .	.36 MoReg 1516 . . . . .	May 15, 2011 . . . . .Feb. 23, 2012
19 CSR 73-2.022	Procedures and Requirements for Licensure of Residential Care and Assisted Living Administrators . . . . .	.36 MoReg 1517 . . . . .	May 15, 2011 . . . . .Feb. 23, 2012
19 CSR 73-2.025	Licensure by Reciprocity . . . . .	.36 MoReg 1518 . . . . .	May 15, 2011 . . . . .Feb. 23, 2012
19 CSR 73-2.070	Examination . . . . .	.36 MoReg 1519 . . . . .	May 15, 2011 . . . . .Feb. 23, 2012
<b>Department of Insurance, Financial Institutions and Professional Registration</b>			
<b>Missouri State Board of Accountancy</b>			
20 CSR 2010-2.160	Fees . . . . .	.36 MoReg 1795 . . . . .	July 10, 2011 . . . . .Feb. 23, 2012
<b>Advisory Committee</b>			
20 CSR 2015-1.030	Fees . . . . .	.36 MoReg 1173 . . . . .	April 11, 2011 . . . . .Jan. 18, 2012
<b>Committee for Professional Counselors</b>			
20 CSR 2095-1.020	Fees . . . . .	.36 MoReg 1173 . . . . .	April 11, 2011 . . . . .Jan. 18, 2012
<b>State Board of Pharmacy</b>			
20 CSR 2220-2.675	Standards of Operation/Licensure for Class L Veterinary Pharmacies . . . . .	.36 MoReg 2084 . . . . .	Sept. 8, 2011 . . . . .March 5, 2012

Agency	Publication	Effective	Expiration
<b>State Committee of Marital and Family Therapists</b>			
20 CSR 2233-1.040 Fees	Next Issue	Nov. 25, 2012	May 22, 2012
<b>Missouri Family Trust</b>			
<b>Director and Board of Trustees</b>			
21 CSR 10-1.010 General Organization	Next Issue	Nov. 25, 2012	May 22, 2012
21 CSR 10-1.020 Definitions	Next Issue	Nov. 25, 2012	May 22, 2012
21 CSR 10-1.030 Meetings of the Board of Trustees	Next Issue	Nov. 25, 2012	May 22, 2012
21 CSR 10-2.010 Terms and Conditions of the Missouri Family Trust	Next Issue	Nov. 25, 2012	May 22, 2012
21 CSR 10-3.010 Charitable Trust Regulations	Next Issue	Nov. 25, 2012	May 22, 2012
21 CSR 10-4.010 Administrative Fees for Missouri Family Trust Accounts	Next Issue	Nov. 25, 2012	May 22, 2012
21 CSR 10-4.020 Administrative Fees for the Charitable Trust	Next Issue	Nov. 25, 2012	May 22, 2012
<b>Missouri Consolidated Health Care Plan</b>			
<b>Health Care Plan</b>			
22 CSR 10-2.010 Definitions	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.020 General Membership Provisions (Rescission)	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.020 General Membership Provisions	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.030 Contributions	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.045 Plan Utilization Review Policy	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges (Rescission)	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.075 Review and Appeals Procedure	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.090 Pharmacy Benefit Summary	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.091 Wellness Program Coverage, Provisions, and Limitations	This Issue	Nov. 25, 2011	May 22, 2012
22 CSR 10-2.094 Tobacco-Free Incentive Provisions and Limitations	This Issue	Nov. 25, 2011	May 22, 2012
22 CSR 10-2.095 TRICARE Supplement Plan	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-2.100 Fully-Insured Medical Plan Provisions	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.010 Definitions	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.020 Subscriber Agreement and General Membership Provisions (Rescission)	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.020 General Membership Provisions	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.045 Plan Utilization Review Policy	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges (Rescission)	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.075 Review and Appeals Procedure	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.090 Pharmacy Benefit Summary	This Issue	Jan. 1, 2012	June 28, 2012
22 CSR 10-3.100 Fully-Insured Medical Plan Provisions	This Issue	Jan. 1, 2012	June 28, 2012

# Executive Orders

Executive Orders	Subject Matter	Filed Date	Publication
	<b>2011</b>		
11-23	Extends Executive Order 11-20 until October 15, 2011, and extends Executive Orders 11-06, 11-07, 11-08, 11-11, 11-14, and 11-18 until December 18, 2011	Sept. 13, 2011	36 MoReg 2157
11-22	Designates members of the governor's staff to have supervisory authority over certain departments, divisions, and agencies	July 26, 2011	36 MoReg 1979
11-21	Authorizes the Joplin Public School system to immediately begin to retrofit, equip, and furnish various buildings to house students during the 2011-2012 school year without requiring advertisements for bids	June 17, 2011	36 MoReg 1800
11-20	Extends certain terms of Executive Order 11-12 to help Missouri citizens impacted by the Joplin tornado of April 22, 2011	June 17, 2011	36 MoReg 1798
11-19	Extends certain terms of Executive Orders 11-06, 11-07, 11-08, 11-10, 11-11, 11-13, 11-14, 11-15, 11-16, and 11-18 until September 15, 2011	June 17, 2011	36 MoReg 1796
11-18	Activates the state militia in response to flooding events occurring and threatening along the Missouri River	June 8, 2011	36 MoReg 1739
11-17	Establishes the State of Missouri Resource, Recovery & Rebuilding Center in the City of Joplin in response to a tornado that struck there on May 22, 2011	June 7, 2011	36 MoReg 1737
11-16	Authorizes the Joplin Public Schools to immediately begin to retrofit and furnish warehouse and retail structures to house district programs displaced by the tornado and severe storms on May 22, 2011, without requiring advertisements for bids	June 3, 2011	36 MoReg 1735
11-15	Authorizes the Joplin Public School system to immediately rebuild, restore, and/or renovate Emerson Elementary, Kelsey Norman Elementary, Old South Middle School, and Washington Education Center without requiring advertisement for bids	June 1, 2011	36 MoReg 1594
11-14	Activates the state militia in response to a tornado that hit the City of Joplin on May 22, 2011	May 26, 2011	36 MoReg 1592
11-13	Authorizes the Joplin Public Schools system to immediately begin rebuilding and replacing the materials for three of its buildings that were destroyed in a tornado that struck on May 22, 2011, without requiring advertisement for bids	May 26, 2011	36 MoReg 1590
11-12	Orders the director of the Department of Insurance, Financial Institutions and Professional Registration to temporarily waive, suspend, and/or modify any statute or regulation under his purview in order to best serve the interests of those citizens affected by the tornado that hit the city of Joplin on May 22, 2011	May 26, 2011	36 MoReg 1587
11-11	Orders the director of revenue to issue duplicate or replacement license, nondriver license, certificate of motor vehicle ownership, number plate, or tabs lost or destroyed as a result of the tornado that hit the city of Joplin and to waive all state fees and charges for such duplicate or replacement	May 26, 2011	36 MoReg 1585
11-10	Orders the Missouri Department of Health and Senior Services and the State Board of Pharmacy to temporarily waive certain rules and regulations to allow medical practitioners and pharmacists responding to the tornado and severe storms in Joplin to best serve the interests of public health and safety	May 24, 2011	36 MoReg 1583
11-09	Extends Executive Orders 11-06, 11-07, and 11-08 through June 20, 2011	May 20, 2011	36 MoReg 1581
11-08	Activates the state militia in response to severe weather that began on April 22	April 25, 2011	36 MoReg 1449
11-07	Gives the director of the Department of Natural Resources the authority to temporarily suspend regulations in the aftermath of severe weather that began on April 22	April 25, 2011	36 MoReg 1447
11-06	Declares a state of emergency for the state of Missouri and activates the Missouri State Emergency Operations Plan due to severe weather that began on April 22	April 22, 2011	36 MoReg 1445
11-05	Orders the Missouri Department of Transportation to assist local jurisdictions in counties that: 1) received record snowfalls; and 2) continuing snow clearance exceeds their capabilities	Feb. 4, 2011	36 MoReg 883
11-04	Activates the state militia in response to severe weather that began on January 31, 2011	Jan. 31, 2011	36 MoReg 881
11-03	Declares a state of emergency exists in the state of Missouri and directs that the Missouri State Emergency Operations Plan be activated	Jan. 31, 2011	36 MoReg 879

**Executive  
Orders****Subject Matter****Filed Date****Publication**

<b>11-02</b>	Extends the declaration of emergency contained in Executive Order 10-27 and the terms of Executive Order 11-01 through February 28, 2011	Jan. 28, 2011	36 MoReg 877
<b>11-01</b>	Gives the Director of the Department of Natural Resources the authority to temporarily suspend regulations in the aftermath of severe winter weather that began on December 30	Jan. 4, 2011	36 MoReg 705
<b>2010</b>			
<b>10-27</b>	Declares a state of emergency and directs the Missouri State Emergency Operations Plan be activated due to severe weather that began on December 30	Dec. 31, 2010	36 MoReg 446
<b>Emergency Declaration</b>	Proclaims an emergency declaration concerning the damage and structural integrity of the State Route A bridge over the Weldon Fork of the Thompson River	Sept. 28, 2010	35 MoReg 1531
<b>10-26</b>	Designates members of the governor's staff to have supervisory authority over certain departments, divisions, and agencies	Sept. 24, 2010	35 MoReg 1529
<b>10-25</b>	Extends the declaration of emergency contained in Executive Order 10-22 for the purpose of protecting the safety and welfare of our fellow Missourians	July 20, 2010	35 MoReg 1244
<b>10-24</b>	Creates the Code of Fair Practices for the Executive Branch of State Government and supersedes paragraph one of Executive Order 05-30	July 9, 2010	35 MoReg 1167
<b>Emergency Declaration</b>	Proclaims that an emergency exists concerning the damage and structural integrity of the U.S. Route 24 bridge over the Grand River	July 2, 2010	35 MoReg 1165
<b>10-23</b>	Activates the state militia in response to severe weather that began on June 12	June 23, 2010	35 MoReg 1078
<b>10-22</b>	Declares a state of emergency and directs the Missouri State Emergency Operations Plan be activated due to severe weather that began on June 12	June 21, 2010	35 MoReg 1076
<b>10-21</b>	Activates the Missouri State Emergency Operations Center	June 15, 2010	35 MoReg 1018
<b>10-20</b>	Establishes the Missouri Civil War Sesquicentennial Commission	April 2, 2010	35 MoReg 754
<b>10-19</b>	Amends Executive Order 09-17 to give the commissioner of the Office of Administration supervisory authority over the Transform Missouri Project	March 2, 2010	35 MoReg 637
<b>10-18</b>	Establishes the Children in Nature Challenge to challenge Missouri communities to take action to enhance children's education about nature, and to increase children's opportunities to personally experience nature and the outdoors	Feb. 26, 2010	35 MoReg 573
<b>10-17</b>	Establishes a Missouri Emancipation Day Commission to promote, consider, and recommend appropriate activities for the annual recognition and celebration of Emancipation Day	Feb. 2, 2010	35 MoReg 525
<b>10-16</b>	Transfers the scholarship portion of the A+ Schools Program from the Missouri Department of Elementary and Secondary Education to the Missouri Department of Higher Education	Jan. 29, 2010	35 MoReg 447
<b>10-15</b>	Transfers the Breath Alcohol Program from the Missouri Department of Transportation to the Missouri Department of Health and Senior Services	Jan. 29, 2010	35 MoReg 445
<b>10-14</b>	Designates members of the governor's staff to have supervisory authority over certain departments, divisions, and agencies	Jan. 29, 2010	35 MoReg 443
<b>10-13</b>	Directs the Department of Social Services to disband the Missouri Task Force on Youth Aging Out of Foster Care	Jan. 15, 2010	35 MoReg 364
<b>10-12</b>	Rescinds Executive Orders 98-14, 95-21, 95-17, and 94-19 and terminates the Governor's Commission on Driving While Intoxicated and Impaired Driving	Jan. 15, 2010	35 MoReg 363
<b>10-11</b>	Rescinds Executive Order 05-41 and terminates the Governor's Advisory Council for Veterans Affairs and assigns its duties to the Missouri Veterans Commission	Jan. 15, 2010	35 MoReg 362
<b>10-10</b>	Rescinds Executive Order 01-08 and terminates the Personal Independence Commission and assigns its duties to the Governor's Council on Disability	Jan. 15, 2010	35 MoReg 361
<b>10-09</b>	Rescinds Executive Orders 95-10, 96-11, and 98-13 and terminates the Governor's Council on AIDS and transfers their duties to the Statewide HIV/STD Prevention Community Planning Group within the Department of Health and Senior Services	Jan. 15, 2010	35 MoReg 360
<b>10-08</b>	Rescinds Executive Order 04-07 and terminates the Missouri Commission on Patient Safety	Jan. 15, 2010	35 MoReg 358
<b>10-07</b>	Rescinds Executive Order 01-16 and terminates the Missouri Commission on Intergovernmental Cooperation	Jan. 15, 2010	35 MoReg 357
<b>10-06</b>	Rescinds Executive Order 05-13 and terminates the Governor's Advisory Council on Plant Biotechnology and assigns its duties to the Missouri Technology Corporation	Jan. 15, 2010	35 MoReg 356



**Executive  
Orders**

	<b>Subject Matter</b>	<b>Filed Date</b>	<b>Publication</b>
<b>10-05</b>	Rescinds Executive Order 95-28 and terminates the Missouri Board of Geographic Names	Jan. 15, 2010	35 MoReg 355
<b>10-04</b>	Rescinds Executive Order 03-10 and terminates the Missouri Energy Policy Council	Jan. 15, 2010	35 MoReg 354
<b>10-03</b>	Rescinds Executive Order 03-01 and terminates the Missouri Lewis and Clark Bicentennial Commission	Jan. 15, 2010	35 MoReg 353
<b>10-02</b>	Rescinds Executive Order 07-29 and terminates the Governor's Advisory Council on Aging and assigns its duties to the State Board of Senior Services	Jan. 15, 2010	35 MoReg 352
<b>10-01</b>	Rescinds Executive Order 01-15 and terminates the Missouri Commission on Total Compensation	Jan. 15, 2010	35 MoReg 351

The rule number and the MoReg publication date follow each entry to this index.

**ACCOUNTANCY, MISSOURI STATE BOARD OF**  
fees; 20 CSR 2010-2.160; 8/1/11, 12/1/11

**ADMINISTRATION, OFFICE OF**

equal opportunity, office of  
definitions; 1 CSR 10-17.010; 7/1/11, 10/17/11  
minority and women's business enterprise participation in procurement process; 1 CSR 10-17.050; 7/1/11, 10/17/11  
minority/women business enterprise certification; 1 CSR 10-17.040; 7/1/11, 10/17/11  
facilities management, design and construction, division of  
drug & alcohol testing program requirements; 1 CSR 30-7.010; 7/1/11, 11/15/11  
minority/women business enterprise and service disabled veteran business enterprise participation in state construction contracts; 1 CSR 30-5.010; 7/1/11, 10/17/11  
purchasing and materials management  
definitions; 1 CSR 40-1.030; 7/1/11, 10/17/11  
procedures for solicitation, receipt of bids, and award and administration of contracts; 1 CSR 40-1.050; 7/1/11, 10/17/11  
vendor registration, notification of bidding opportunities, suspension, and debarment; 1 CSR 40-1.060; 7/1/11, 10/17/11

**ADJUTANT GENERAL**

FEMA notice to the public of its intent to reimburse state and local governments and agencies, and eligible private non-profit organizations for eligible costs incurred to repair and/or replace facilities damaged by severe storms, tornadoes, and flooding occurring from June 1, 2011 to August 1, 2011; 11 CSR 10-11; 11/1/11

**AGRICULTURE**

animal health  
animal care facility definitions; 2 CSR 30-9.010; 8/15/11, 9/1/11  
animal care facility minimum standards of operation and transportation; 2 CSR 30-9.030; 8/15/11, 9/1/11  
animal care facility rules governing licensing, fees, reports, record keeping, veterinary care, identification, and holding period; 2 CSR 30-9.020; 8/15/11, 9/1/11  
Eurasian, Russian, and captured feral swine facility act definitions; 2 CSR 30-9.100; 8/1/11  
feral swine confinement permit and standards; 2 CSR 30-9.110; 8/1/11  
large carnivore act  
definitions; 2 CSR 30-9.040; 8/1/11  
permit and standards; 2 CSR 30-9.050; 8/1/11  
movement of livestock, poultry, and exotic animals within Missouri; 2 CSR 30-2.020; 9/1/11  
plant industries  
noxious weed list; 2 CSR 70-45.005; 10/3/11, 10/17/11  
state milk board  
Grade A Milk policies; 2 CSR 80-2.190; 8/1/11, 11/15/11

**AIR QUALITY, AIR POLLUTION CONTROL**

certain coals to be washed; 10 CSR 10-5.130; 11/1/11  
control of emissions from  
hand-fired equipment; 10 CSR 10-5.040; 11/1/11  
industrial solvent cleaning operations; 10 CSR 10-5.455; 11/1/11  
control of heavy duty diesel vehicle idling emissions  
10 CSR 10-2.385; 12/1/11  
10 CSR 10-5.385; 12/1/11

definitions and common reference tables; 10 CSR 10-6.020; 11/1/11  
emission standards for hazardous air pollutants; 10 CSR 10-6.080; 8/1/11  
maximum achievable control technology regulations; 10 CSR 10-6.075; 8/1/11  
municipal solid waste-landfills; 10 CSR 10-5.490; 11/1/11  
new source performance regulations; 10 CSR 10-6.070; 8/1/11  
restriction of emission of particulate matter from industrial sources; 10 CSR 10-6.400; 11/1/11  
restriction of emissions from municipal waste landfills; 10 CSR 10-6.310; 11/1/11

**ARCHITECTS, PROFESSIONAL ENGINEERS, PROFESSIONAL LAND SURVEYORS, AND LANDSCAPE ARCHITECTS, MISSOURI BOARD FOR**

continuing education for landscape architects; 20 CSR 2030-11.035; 12/1/11  
continuing professional competency for professional engineers; 20 CSR 2030-11.015; 12/1/11  
definitions; 20 CSR 2030-14.050; 12/1/11  
standards of care; 20 CSR 2030-2.040; 12/1/11  
title block; 20 CSR 2030-2.050; 12/1/11

**ATTORNEY GENERAL**

methods by which a person or entity desiring to make telephone solicitations will obtain access to the database of residential subscriber's notice of objection to receiving telephone solicitations and the cost assessed for access to the database; 15 CSR 60-13.060; 11/1/11

**CERTIFICATE OF NEED PROGRAM**

application review schedule; 19 CSR 60-50; 10/3/11, 11/1/11, 12/1/11

**CHIROPRACTIC EXAMINERS, STATE BOARD OF**

fees; 20 CSR 2070-2.090; 11/15/10

**CLEAN WATER COMMISSION**

administrative penalty assessment; 10 CSR 20-13.080; 5/16/11, 11/1/11  
allowable mechanisms and combinations of mechanisms; 10 CSR 20-11.094; 5/16/11, 11/1/11  
amount and scope of required financial responsibility; 10 CSR 20-11.093; 5/16/11, 11/1/11  
applicability  
10 CSR 20-10.010; 5/16/11, 11/1/11  
10 CSR 20-11.090; 5/16/11, 11/1/11  
applicability and definitions; 10 CSR 20-15.010; 5/16/11, 11/1/11  
applicability to previously closed underground storage tank systems; 10 CSR 20-10.073; 5/16/11, 11/1/11  
assessing the site at closure or change in service; 10 CSR 20-10.072; 5/16/11, 11/1/11  
bankruptcy or other incapacity of owner or operator, or provider of financial assurance; 10 CSR 20-11.110; 5/16/11, 11/1/11  
cancellation or nonrenewable by a provider of financial assurance; 10 CSR 20-11.105; 5/16/11, 11/1/11  
closure records; 10 CSR 20-10.074; 5/16/11, 11/1/11  
compatibility; 10 CSR 20-10.032; 5/16/11, 11/1/11  
compliance dates; 10 CSR 20-11.091; 5/16/11, 11/1/11  
concentrated animal feeding operations; 10 CSR 20-6.300; 8/15/11  
construction and operating permits; 10 CSR 20-6.010; 8/15/11  
corrective action plan; 10 CSR 20-10.066; 5/16/11, 11/1/11  
definitions; 10 CSR 20-10.012; 5/16/11, 11/1/11  
definitions of financial responsibility terms; 10 CSR 20-11.092; 5/16/11, 11/1/11  
design of gravity sewers; 10 CSR 20-8.120; 8/1/11

drawing on financial assurance mechanisms; 10 CSR 20-11.108; 5/16/11, 11/1/11  
financial test of self-insurance; 10 CSR 20-11.095; 5/16/11, 11/1/11  
free-product removal; 10 CSR 20-10.064; 5/16/11, 11/1/11  
general requirements for release detection for all underground storage tank systems; 10 CSR 20-10.040; 5/16/11, 11/1/11  
guarantee; 10 CSR 20-11.096; 5/16/11, 11/1/11  
interim prohibition for deferred underground storage tank systems; 10 CSR 20-10.011; 5/16/11, 11/1/11  
initial abatement measures; 10 CSR 20-10.062; 5/16/11, 11/1/11  
initial release response and corrective action; 10 CSR 20-10.061; 5/16/11, 11/1/11  
initial site characterization; 10 CSR 20-10.063; 5/16/11, 11/1/11  
insurance and risk retention group coverage; 10 CSR 20-11.097; 5/16/11, 11/1/11  
investigation due to off-site impacts; 10 CSR 20-10.051; 5/16/11, 11/1/11  
investigations for soil and groundwater cleanup; 10 CSR 20-10.065; 5/16/11, 11/1/11  
letter of credit; 10 CSR 20-11.099; 5/16/11, 11/1/11  
local government bond rating test; 10 CSR 20-11.112; 5/16/11, 11/1/11  
local government financial test; 10 CSR 20-11.113; 5/16/11, 11/1/11  
local government fund; 10 CSR 20-11.115; 5/16/11, 11/1/11  
local government guarantee; 10 CSR 20-11.114; 5/16/11, 11/1/11  
manure storage design regulations; 10 CSR 20-8.300; 8/15/11, methods of release detection for piping; 10 CSR 20-10.044; 5/16/11, 11/1/11  
methods of release detection for tanks; 10 CSR 20-10.043; 5/16/11, 11/1/11  
notification requirements; 10 CSR 20-10.022; 5/16/11, 11/1/11  
operation and maintenance of corrosion protection; 10 CSR 20-10.031; 5/16/11, 11/1/11  
performance standards for new underground storage tank systems; 10 CSR 20-10.020; 5/16/11, 11/1/11  
permanent closure and changes in service; 10 CSR 20-10.071; 5/16/11, 11/1/11  
petroleum storage tank insurance fund; 10 CSR 20-11.101; 5/16/11, 11/1/11  
public participation; 10 CSR 20-10.067; 5/16/11, 11/1/11  
record keeping; 10 CSR 20-11.107; 5/16/11, 11/1/11  
release detection record keeping; 10 CSR 20-10.045; 5/16/11, 11/1/11  
release from the requirements; 10 CSR 20-11.109; 5/16/11, 11/1/11  
release investigation and confirmation steps; 10 CSR 20-10.052; 5/16/11, 11/1/11  
release reporting and initial release response measures; 10 CSR 20-15.020; 5/16/11, 11/1/11  
release response and corrective action; 10 CSR 20-10.060; 5/16/11, 11/1/11  
repairs allowed; 10 CSR 20-10.033; 5/16/11, 11/1/11  
replenishment of guarantees, letters of credit, or surety bonds; 10 CSR 20-11.111; 5/16/11, 11/1/11  
reporting and cleanup of spills and overfills; 10 CSR 20-10.053; 5/16/11, 11/1/11  
reporting and record keeping; 10 CSR 20-10.034; 5/16/11, 11/1/11  
reporting by owner or operator; 10 CSR 20-11.106; 5/16/11, 11/1/11  
reporting of suspected releases; 10 CSR 20-10.050; 5/16/11, 11/1/11  
requirements for hazardous substance underground storage tank systems; 10 CSR 20-10.042; 5/16/11, 11/1/11  
requirements for petroleum underground storage tank systems; 10 CSR 20-10.041; 5/16/11, 11/1/11  
risk-based target levels; 10 CSR 20-10.068; 5/16/11, 11/1/11  
site characterization and corrective action; 10 CSR 20-15.030; 5/16/11, 11/1/11  
spill and overflow control; 10 CSR 20-10.030; 5/16/11, 11/1/11  
standby trust fund; 10 CSR 20-11.103; 5/16/11  
substitution of financial assurance mechanisms; 10 CSR 20-11.104; 5/16/11, 11/1/11  
surety bond; 10 CSR 20-11.098; 5/16/11, 11/1/11  
taking USTs out of use; 10 CSR 20-10.070; 5/16/11, 11/1/11

trust fund; 10 CSR 20-11.102; 5/16/11, 11/1/11  
upgrading of existing underground storage tank systems; 10 CSR 20-10.021; 5/16/11, 11/1/11  
water quality tables; 10 CSR 20-7.031; 12/1/11

## CONSERVATION COMMISSION

bullfrogs and green frogs  
3 CSR 10-11.165; 10/17/11  
3 CSR 10-12.115; 10/17/11  
camping; 3 CSR 10-11.140; 10/17/11  
closed hours; 3 CSR 10-12.109; 10/17/11  
closings; 3 CSR 10-11.115; 10/17/11  
commercial deer processing; permit, privileges, requirements; 3 CSR 10-10.744; 10/17/11  
deer  
firearms hunting seasons; 3 CSR 10-7.433; 10/17/11  
hunting seasons: general provisions; 3 CSR 10-7.431; 10/17/11  
dove hunting; 3 CSR 10-11.185; 10/17/11  
field trials; 3 CSR 10-11.125; 10/17/11  
fishing  
daily and possession limits; 3 CSR 10-12.140; 10/17/11  
general provisions and seasons  
3 CSR 10-11.200; 10/17/11  
3 CSR 10-12.130; 10/17/11  
length limits  
3 CSR 10-11.215; 10/17/11  
3 CSR 10-12.145; 10/17/11  
methods; 3 CSR 10-12.135; 10/17/11  
methods and hours; 3 CSR 10-11.205; 10/17/11  
trout parks; 3 CSR 10-12.150; 10/17/11  
general prohibition; applications; 3 CSR 10-9.110; 10/17/11  
general provisions; 3 CSR 10-11.110; 10/17/11  
hunting  
and trapping; 3 CSR 10-12.125; 10/17/11  
general provisions and seasons; 3 CSR 10-11.180; 10/17/11  
methods; 3 CSR 10-7.410; 10/17/11  
migratory game birds and waterfowl: seasons, limits; 3 CSR 10-7.440; 10/3/11  
permits required; exceptions; 3 CSR 10-5.205; 10/17/11  
resident and nonresident permits; 3 CSR 10-5.220; 10/17/11  
restricted zones; 3 CSR 10-6.415; 10/17/11  
turkey: seasons, methods, limits; 3 CSR 10-7.455; 10/17/11  
use of boats and motors  
3 CSR 10-11.160; 10/17/11  
3 CSR 10-12.110; 10/17/11  
vehicles, bicycles, horses, and horseback riding; 3 CSR 10-11.130; 10/17/11  
waterfowl hunting; 3 CSR 10-11.186; 10/17/11

## CREDIT UNIONS, DIVISION OF

allowance for loan loss; 20 CSR 1100-2.055; 10/3/11  
loans; 20 CSR 1100-2.040; 10/3/11  
mergers and consolidations; 20 CSR 1100-2.075; 10/3/11  
rules of procedure; 20 CSR 1100-2.240; 10/3/11

## DRINKING WATER COMMISSION, SAFE

acceptable and alternative methods for analysis; 10 CSR 60-5.010; 11/15/11  
applicability of corrosion control treatment steps to small, medium-size, and large water systems; 10 CSR 60-15.020; 11/15/11  
consumer confidence reports; 10 CSR 60-8.030; 11/15/11  
general requirements; 10 CSR 60-15.010; 11/15/11  
lead service line replacement requirements; 10 CSR 60-15.050; 11/15/11  
monitoring requirements for  
lead and copper in  
source water; 10 CSR 60-15.090; 11/15/11  
tap water; 10 CSR 60-15.070; 11/15/11

water quality parameters; 10 CSR 60-15.080; 11/15/11  
public education and supplemental monitoring requirements; 10 CSR 60-15.060; 11/15/11  
public education requirements; 10 CSR 60-15.060; 11/15/11  
reporting requirements for lead and copper monitoring; 10 CSR 60-7.020; 11/15/11  
source water treatment requirements; 10 CSR 60-15.040; 11/15/11

#### **ELEMENTARY AND SECONDARY EDUCATION, DEPARTMENT OF**

A+ Schools Program; 5 CSR 50-350.040; 8/2/10  
administrative and financial services, division of; 5 CSR 30; 10/3/11  
applied music credit; 5 CSR 50-340.021; 10/3/11  
approval of utilizing courses delivered primarily through electronic media; 5 CSR 50-340.100; 10/3/11  
career education, division of; 5 CSR 60; 10/3/11  
financial and administrative services, division of; 5 CSR 30; 10/3/11  
general provisions; 5 CSR 50-350.010; 10/3/11  
general provisions governing the consolidated grants under the Improving America's Schools Act; 5 CSR 50-321.010; 6/1/10  
learning services, division of  
5 CSR 20-100; 10/3/11  
5 CSR 20-200; 10/3/11  
5 CSR 20-300; 10/3/11  
5 CSR 20-400; 10/3/11  
5 CSR 20-500; 10/3/11  
5 CSR 20-600; 10/3/11  
measurement of effectiveness of remediation of students scoring at the lowest level on the Missouri Assessment Program; 5 CSR 30-345.011; 10/3/11  
military service credit  
5 CSR 50-340.018; 10/3/11  
5 CSR 50-340.049; 10/3/11  
Missouri school improvement program-5; 5 CSR 20-100.105; 10/3/11  
persistence to graduation program grants; 5 CSR 50-350.050; 10/3/11  
policies and standards for part-time public school students; 5 CSR 50-340.060; 10/3/11  
priority schools; 5 CSR 50-340.100; 10/3/11  
safe schools curriculum; 5 CSR 50-350.030; 10/3/11  
safe schools educational program grants; 5 CSR 50-350.020; 10/3/11  
school improvement, division of; 5 CSR 50; 10/3/11  
special education, division of; 5 CSR 70; 10/3/11  
standards for Missouri school library media center; 5 CSR 50-340.030; 10/3/11  
standards for part-time schools; 5 CSR 50-340.070; 10/3/11  
state reading circle program; 5 CSR 50-340.022; 10/3/11  
success leads to success program; 5 CSR 50-870.010; 10/3/11  
teacher quality and urban education; 5 CSR 80; 10/3/11  
vocational rehabilitation, division of; 5 CSR 90; 10/3/11

#### **EXECUTIVE ORDERS**

extends Executive Order 11-20 until October 15, 2011, and extends Executive Orders 11-06, 11-07, 11-08, 11-11, 11-14, 11-18 until December 18, 2011; 11-23, 10/17/11

#### **FAMILY SUPPORT DIVISION**

definition of adoption services; 13 CSR 40-38.010; 7/1/10, 10/15/10  
provision of adoption services; 13 CSR 40-38.020; 7/1/10, 10/15/10

#### **GAMING COMMISSION, MISSOURI**

code of ethics; 11 CSR 45-1.015; 11/1/11  
disassociated persons  
confidentiality of list of; 11 CSR 45-17.040; 10/3/11  
list created-right to remove from premises; 11 CSR 45-17.010; 10/3/11  
procedure for applying for placement on list of; 11 CSR 45-17.020; 10/3/11  
procedure for entry of names onto list of; 11 CSR 45-17.030; 10/3/11  
procedure to discontinue self-exclusion on the list of; 11 CSR 45-17.060; 10/3/11  
procedure to re-establish self-exclusion on the list of; 11 CSR 45-17.070; 10/3/11  
removal from list prohibited; 11 CSR 45-17.050; 10/3/11  
electronic gaming device authentication; 11 CSR 45-5.192; 5/2/11, 10/3/11  
emergency medical services (EMS) first responder required; 11 CSR 45-7.160; 10/3/11  
junket-agreements and final reports  
11 CSR 45-4.540; 5/2/11  
11 CSR 45-5.420; 5/2/11, 10/3/11  
junket arrangements-criteria by which patrons selected determinant of junket; 11 CSR 45-4.520; 5/2/11, 10/3/11  
junket, junket enterprises, junket representatives-definitions  
11 CSR 45-4.500; 5/2/11  
11 CSR 45-5.400; 5/2/11, 10/3/11  
junket enterprise; junket representative; agents; employees-policies and prohibited activities  
11 CSR 45-4.530; 5/2/11  
11 CSR 45-5.410; 5/2/11, 10/3/11  
junket enterprise; junket representative-licensing requirements; 11 CSR 45-4.510; 5/2/11, 10/3/11  
licenses, restrictions on licenses, licensing authority of the executive director, and other definitions; 11 CSR 45-4.020; 5/2/11, 10/3/11  
minimum internal control standards (MICS)-chapter H; 11 CSR 45-9.108; 12/1/11  
minimum internal control standards (MICS)-chapter N; 11 CSR 45-9.114; 10/3/11  
minimum internal control standards (MICS)-chapter Q; 11 CSR 45-9.117; 10/3/11  
operator content delivery systems; 11 CSR 45-5.194; 7/1/11, 12/1/11  
participation in gambling games by a holder of a Class A or supplier license, and the directors, officers, key persons or employees of such licensees; 11 CSR 45-5.030; 11/1/11  
participation in games by employees of the commission; 11 CSR 45-1.080; 11/1/11  
patrons unlawfully on excursion gambling boat-not eligible for gambling game winnings; 11 CSR 45-5.065; 11/1/11  
progressive slot machine; 11 CSR 45-5.200; 9/1/11  
rules of liquor control; 11 CSR 45-12.090; 11/1/11  
supplier's license; 11 CSR 45-4.200; 5/2/11, 10/3/11

#### **GEOLOGY AND LAND SURVEY, DIVISION OF**

qualifications; 10 CSR 23-1.050; 10/17/11

#### **HEALING ARTS, STATE BOARD OF REGISTRATION FOR THE**

applicants for licensure as  
athletic trainers; 20 CSR 2150-6.020; 12/1/11  
professional physical therapists; 20 CSR 2150-3.010; 12/1/11  
code of ethics; 20 CSR 2150-6.040; 12/1/11  
definitions; 20 CSR 2150-6.010; 12/1/11  
determination of competency; 20 CSR 2150-2.015; 11/1/11  
examination; 20 CSR 2150-2.020; 11/1/11  
examination requirements for permanent licensure; 20 CSR 2150-2.005; 11/1/11  
late registration and reinstatement; 20 CSR 2150-6.062; 12/1/11  
licensing  
by endorsement; 20 CSR 2150-2.035; 11/1/11  
by reciprocity; 20 CSR 2150-2.030; 11/1/11  
of international medical graduates-reciprocity; 20 CSR 2150-2.100; 11/1/11

minimum requirements for reinstatement of licensure; 20 CSR 2150-2.150; 12/1/11  
postgraduate training requirements for permanent licensure; 20 CSR 2150-2.004; 11/1/11

#### **HAZARDOUS WASTE MANAGEMENT COMMISSION**

definitions, modifications to incorporations and confidential business information; 10 CSR 25-3.260; 5/16/11, 11/1/11  
interim status standards for owners and operators of hazardous waste treatment, storage, and disposal facilities; 10 CSR 25-7.265; 5/16/11, 11/1/11  
land disposal restrictions; 10 CSR 25-7.268; 5/16/11, 11/1/11  
methods for identifying hazardous waste; 10 CSR 25-4.261; 5/16/11, 11/1/11  
Missouri administered permit programs: the hazardous waste permit program; 10 CSR 25-7.270; 5/16/11, 11/1/11  
polychlorinated biphenyls; 10 CSR 25-13.010; 5/16/11, 11/1/11  
procedures for decision making; 10 CSR 25-8.124; 5/16/11, 11/1/11  
recycled used oil management standards; 10 CSR 25-11.279; 5/16/11, 11/1/11  
standards

- applicable to generators of hazardous waste; 10 CSR 25-5.262; 5/16/11, 11/1/11
- for owners and operators of hazardous waste treatment, storage, and disposal facilities; 10 CSR 25-7.264; 5/16/11, 11/1/11
- for the management of specific hazardous wastes and specific types of hazardous waste management facilities; 10 CSR 25-7.266; 5/16/11, 11/1/11
- for transporters of hazardous waste; 10 CSR 25-6.263; 5/16/11, 11/1/11
- for universal waste management; 10 CSR 25-16.273; 5/16/11, 11/1/11

#### **HEALTH AND SENIOR SERVICES**

controlled substances

- dispensing by individual practitioners; 19 CSR 30-1.066; 6/1/11, 10/17/11
- registration changes; 19 CSR 30-1.023; 6/1/11, 10/17/11
- registration location; 19 CSR 30-1.019; 6/1/11, 10/17/11
- registration process; 19 CSR 30-1.017; 6/1/11, 10/17/11
- registrations and fees; 19 CSR 30-1.015; 6/1/11, 10/17/11

hospitals

- safe patient handling and movement in hospitals; 19 CSR 30-20.097; 6/1/11, 10/17/11

nursing home administrators, Missouri board of

- definitions; 19 CSR 73-2.010; 6/15/11, 7/1/11, 12/1/11
- duplicate license; 19 CSR 73-2.120; 6/15/11, 7/1/11, 12/1/11
- examination; 19 CSR 73-2.070; 6/15/11, 7/1/11, 12/1/11
- fees; 19 CSR 73-2.015; 6/15/11, 7/1/11, 12/1/11
- general organization; 19 CSR 73-1.010; 6/15/11, 7/1/11, 12/1/11

- inactive licensure status; 19 CSR 73-2.053; 6/15/11, 7/1/11, 12/1/11

- licensure by reciprocity; 19 CSR 73-2.025; 6/15/11, 7/1/11, 12/1/11

- notice of change of address; 19 CSR 73-2.130; 6/15/11, 7/1/11, 12/1/11

- prescribed course of instruction and training; 19 CSR 73-2.031; 6/15/11, 7/1/11, 12/1/11

- procedures and requirements for licensure of nursing home administrators; 19 CSR 73-2.020; 6/15/11, 7/1/11, 12/1/11

- residential care and assisted living administrators; 19 CSR 73-2.022; 6/15/11, 7/1/11, 12/1/11

- public complaints; 19 CSR 73-2.085; 6/15/11, 7/1/11, 12/1/11

- renewal of expired license; 19 CSR 73-2.055; 6/15/11, 7/1/11, 12/1/11

- licenses; 19 CSR 73-2.050; 6/15/11, 7/1/11, 12/1/11
- retired licensure status; 19 CSR 73-2.051; 6/15/11, 7/1/11, 12/1/11

temporary emergency licenses; 19 CSR 73-2.080; 6/15/11, 7/1/11, 12/1/11

#### **HIGHER EDUCATION, DEPARTMENT OF**

minority teaching scholarship program; 6 CSR 10-2.200; 7/15/11, 11/1/11  
nursing education incentive program; 6 CSR 10-11.010; 8/15/11, 11/1/11, 12/1/11

#### **HIGHWAYS AND TRANSPORTATION COMMISSION**

skill performance evaluation certificates for commercial drivers; 7 CSR 10-25.010; 11/15/11, 12/1/11

#### **INSURANCE**

state legal expense fund; 20 CSR; 1/3/11

#### **LAND RECLAMATION COMMISSION**

prohibitions and limitations on mining in certain areas; 10 CSR 40-5.010; 8/1/11  
state designation of areas as unsuitable for mining; 10 CSR 40-5.020; 8/1/11

#### **LIBRARY, STATE**

state and federal grants—definitions; 15 CSR 30-200.010; 12/1/11  
state and other grants-in-aid; 15 CSR 30-200.020; 12/1/11

#### **MENTAL HEALTH, DEPARTMENT OF**

health home; 9 CSR 10-5.240; 11/15/11  
intermediate care facility for the mentally retarded and federal reimbursement allowance; 9 CSR 10-31.030; 10/3/11

#### **MISSOURI CONSOLIDATED HEALTH CARE PLAN**

general organization; 22 CSR 10-1.010; 12/1/11  
public records; 22 CSR 10-1.020; 12/1/11  
public entity membership

- coordination of benefits; 22 CSR 10-3.070; 12/1/11
- definitions; 22 CSR 10-3.010; 12/1/11
- dental benefit summary; 22 CSR 10-3.092; 12/1/11
- dental coverage; 22 CSR 10-3.092; 12/1/11
- fully-insured medical plan provisions; 22 CSR 10-3.100; 12/1/11
- general membership provisions; 22 CSR 10-3.020; 12/1/11
- pharmacy benefit summary; 22 CSR 10-3.090; 12/1/11
- plan benefit provisions and covered charges
  - high deductible health; 22 CSR 10-3.055; 12/1/11
  - medical; 22 CSR 10-3.057; 12/1/11
  - PPO 600; 22 CSR 10-3.056; 12/1/11
  - PPO 1000; 22 CSR 10-3.053; 12/1/11
  - PPO 2000; 22 CSR 10-3.054; 12/1/11
- plan utilization review policy; 22 CSR 10-3.045; 12/1/11
- PPO 600 plan, PPO 1000 plan, PPO 2000 plan, and HDHP limitations; 22 CSR 10-3.060; 12/1/11
- public entity membership agreement and participation period; 22 CSR 10-3.030; 12/1/11
- review and appeals procedure; 22 CSR 10-3.075; 12/1/11
- subscribers agreement and general membership provisions; 22 CSR 10-3.020; 12/1/11
- vision benefit summary; 22 CSR 10-3.093; 12/1/11
- vision coverage; 22 CSR 10-3.093; 12/1/11

state membership

- coordination of benefits; 22 CSR 10-2.070; 12/1/11
- contributions; 22 CSR 10-2.030; 12/1/11
- definitions; 22 CSR 10-2.010; 12/1/11
- dental benefit summary; 22 CSR 10-2.092; 12/1/11
- dental coverage; 22 CSR 10-2.092; 12/1/11
- fully-insured medical plan provisions; 22 CSR 10-2.100; 12/1/11
- general membership provisions; 22 CSR 10-2.020; 12/1/11
- pharmacy benefit summary; 22 CSR 10-2.090; 12/1/11
- plan benefit provisions and covered charges
  - high deductible health; 22 CSR 10-2.053; 12/1/11
  - medical; 22 CSR 10-2.055; 12/1/11
  - Medicare supplement; 22 CSR 10-2.054; 12/1/11

PPO 300; 22 CSR 10-2.051; 12/1/11  
 PPO 600; 22 CSR 10-2.052; 12/1/11  
 plan utilization review policy; 22 CSR 10-2.045; 12/1/11  
 PPO 300 plan, PPO 600 plan, and HDHP limitations; 22 CSR 10-2.060; 12/1/11  
 review and appeals procedure; 22 CSR 10-2.075; 12/1/11  
 tobacco-free incentive provisions and limitations; 22 CSR 10-2.094; 12/1/11  
 TRICARE supplement plan; 22 CSR 10-2.095; 12/1/11  
 vision benefit summary; 22 CSR 10-2.093; 12/1/11  
 vision coverage; 22 CSR 10-2.093; 12/1/11  
 wellness program coverage, provisions, and limitations; 22 CSR 10-2.091; 12/1/11

## MO HEALTHNET

dental benefits and limitations, MO HealthNet program; 13 CSR 70-35.010; 11/1/11  
 disproportionate share hospital payments; 13 CSR 70-15.220; 7/1/11, 12/1/11  
 electronic health record incentive program; 13 CSR 70-3.220; 8/1/11, 11/15/11  
 electronic retention of records; 13 CSR 70-3.210; 8/1/11, 11/15/11  
 federal reimbursement allowance (FRA); 13 CSR 70-15.110; 8/1/11, 11/1/11, 12/1/11  
 global per diem adjustments to nursing facility and HIV nursing facility reimbursement rates; 13 CSR 70-10.016; 8/1/11, 11/1/11, 11/15/11  
 inpatient hospital services reimbursement plan; outpatient hospital services reimbursement methodology; 13 CSR 70-15.010; 7/1/11, 12/1/11  
 insure Missouri; 13 CSR 70-4.120; 2/15/08  
 MO HealthNet program benefits for federally-qualified health center services; 13 CSR 70-26.010; 8/1/11, 11/15/11  
 nursing facility reimbursement allowance; 13 CSR 70-10.110; 8/1/11, 11/1/11, 11/15/11  
 pharmacy reimbursement allowance; 13 CSR 70-20.320; 8/2/10  
 prospective outpatient hospital services reimbursement methodology; 13 CSR 70-15.160; 8/1/11, 11/1/11  
 prospective reimbursement plan for nonstate-operated facilities for ICF/MR services; 13 CSR 70-10.030; 11/1/11, 11/15/11  
 supplemental upper payment limit methodology; 13 CSR 70-15.230; 7/1/11, 12/1/11

## MOTOR VEHICLE

regulation of dealer license plates; 12 CSR 10-23.070; 10/3/11

## PETROLEUM AND HAZARDOUS WASTE SUBSTANCE STORAGE TANKS

administrative penalty assessment; 10 CSR 26-4.080; 5/16/11, 11/1/11  
 allowable mechanisms and combinations of mechanisms; 10 CSR 26-3.094; 5/16/11, 11/1/11  
 amount and scope of required financial responsibility; 10 CSR 26-3.093; 5/16/11, 11/1/11  
 applicability  
   10 CSR 26-2.010; 5/16/11, 11/1/11  
   10 CSR 26-3.090; 5/16/11, 11/1/11  
 applicability and definitions; 10 CSR 26-5.010; 5/16/11, 11/1/11  
 applicability to previously closed underground storage tank systems; 10 CSR 26-2.063; 5/16/11, 11/1/11  
 assessing the site at closure or change in service; 10 CSR 26-2.062; 5/16/11, 11/1/11  
 bankruptcy or other incapacity of owner or operator, or provider of financial assurance; 10 CSR 26-3.110; 5/16/11, 11/1/11  
 cancellation or nonrenewable by a provider of financial assurance; 10 CSR 26-3.105; 5/16/11, 11/1/11  
 closure records; 10 CSR 26-2.064; 5/16/11, 11/1/11  
 compatibility; 10 CSR 26-2.032; 5/16/11, 11/1/11  
 corrective action plan; 10 CSR 26-2.082; 5/16/11, 11/1/11  
 definitions; 10 CSR 26-2.012; 5/16/11, 11/1/11

definitions of financial responsibility terms; 10 CSR 26-3.092; 5/16/11, 11/1/11  
 drawing on financial assurance mechanisms; 10 CSR 26-3.108; 5/16/11, 11/1/11  
 financial test of self-insurance; 10 CSR 26-3.095; 5/16/11, 11/1/11  
 free-product removal; 10 CSR 26-2.075; 5/16/11, 11/1/11  
 general requirements for release detection for all underground storage tank systems; 10 CSR 26-2.040; 5/16/11, 11/1/11  
 guarantee; 10 CSR 26-3.096; 5/16/11, 11/1/11  
 interim prohibition for deferred underground storage tank systems; 10 CSR 26-2.011; 5/16/11, 11/1/11  
 initial abatement measures; 10 CSR 26-2.072; 5/16/11, 11/1/11  
 initial release response and corrective action; 10 CSR 26-2.071; 5/16/11, 11/1/11  
 initial site characterization; 10 CSR 26-2.074; 5/16/11, 11/1/11  
 insurance and risk retention group coverage; 10 CSR 26-3.097; 5/16/11, 11/1/11  
 investigation due to off-site impacts; 10 CSR 26-2.051; 5/16/11, 11/1/11  
 investigations for soil and groundwater cleanup; 10 CSR 26-2.078; 5/16/11, 11/1/11  
 letter of credit; 10 CSR 26-3.099; 5/16/11, 11/1/11  
 local government bond rating test; 10 CSR 26-3.112; 5/16/11, 11/1/11  
 local government financial test; 10 CSR 26-3.113; 5/16/11, 11/1/11  
 local government fund; 10 CSR 26-3.115; 5/16/11, 11/1/11  
 local government guarantee; 10 CSR 26-3.114; 5/16/11, 11/1/11  
 methods of release detection for piping; 10 CSR 26-2.044; 5/16/11, 11/1/11  
 methods of release detection for tanks; 10 CSR 26-2.043; 5/16/11, 11/1/11  
 new installation requirements; 10 CSR 26-2.019; 5/16/11, 11/1/11  
 notification requirements; 10 CSR 26-2.022; 5/16/11, 11/1/11  
 operation and maintenance of corrosion protection; 10 CSR 26-2.031; 5/16/11, 11/1/11  
 organization; 10 CSR 26-1.010; 5/16/11, 11/1/11  
 performance standards for new underground storage tank systems; 10 CSR 26-2.020; 5/16/11, 11/1/11  
 permanent closure and changes in service; 10 CSR 26-2.061; 5/16/11, 11/1/11  
 petroleum storage tank insurance fund; 10 CSR 26-3.101; 5/16/11, 11/1/11  
 public participation; 10 CSR 26-2.083; 5/16/11, 11/1/11  
 record keeping; 10 CSR 26-3.107; 5/16/11, 11/1/11  
 release detection record keeping; 10 CSR 26-2.045; 5/16/11, 11/1/11  
 release from the requirements; 10 CSR 26-3.109; 5/16/11, 11/1/11  
 release investigation and confirmation steps; 10 CSR 26-2.052; 5/16/11, 11/1/11  
 release reporting and initial release response measures; 10 CSR 26-5.020; 5/16/11, 11/1/11  
 release response and corrective action; 10 CSR 26-2.070; 5/16/11, 11/1/11  
 repairs allowed; 10 CSR 26-2.033; 5/16/11, 11/1/11  
 replenishment of guarantees, letters of credit, or surety bonds; 10 CSR 26-3.111; 5/16/11, 11/1/11  
 reporting and cleanup of spills and overfills; 10 CSR 26-2.053; 5/16/11, 11/1/11  
 reporting and record keeping; 10 CSR 26-2.034; 5/16/11, 11/1/11  
 reporting by owner or operator; 10 CSR 26-3.106; 5/16/11, 11/1/11  
 reporting of suspected releases; 10 CSR 26-2.050; 5/16/11, 11/1/11  
 requirements for hazardous substance underground storage tank systems; 10 CSR 26-2.042; 5/16/11, 11/1/11  
 requirements for petroleum underground storage tank systems; 10 CSR 26-2.041; 5/16/11, 11/1/11  
 risk-based target levels; 10 CSR 26-2.080; 5/16/11, 11/1/11  
 site characterization and corrective action; 10 CSR 26-5.030; 5/16/11, 11/1/11  
 spill and overfill control; 10 CSR 26-2.030; 5/16/11, 11/1/11  
 standby trust fund; 10 CSR 26-3.103; 5/16/11, 11/1/11

substitution of financial assurance mechanisms; 10 CSR 26-3.104; 5/16/11, 11/1/11  
surety bond; 10 CSR 26-3.098; 5/16/11, 11/1/11  
taking USTs out of use; 10 CSR 26-2.060; 5/16/11, 11/1/11  
trust fund; 10 CSR 26-3.102; 5/16/11, 11/1/11  
upgrading of existing underground storage tank systems; 10 CSR 26-2.021; 5/16/11, 11/1/11

#### PHARMACY, STATE BOARD OF

standards of operation/licensure for class L veterinary pharmacies; 20 CSR 2220-2.675; 10/3/11

#### PROBATION AND PAROLE, STATE BOARD OF

conditions of lifetime supervision; 14 CSR 80-3.020; 12/1/11  
conditions of probation and parole; 14 CSR 80-3.010; 12/1/11  
definitions for intervention fee; 14 CSR 80-5.010; 12/1/11  
intervention fee procedure; 14 CSR 80-5.020; 12/1/11

#### PROPANE GAS COMMISSION, MISSOURI

addressing commission; 2 CSR 90-10.130; 3/1/11  
appearances; 2 CSR 90-10.160; 3/1/11  
container, system, or equipment violations; 2 CSR 90-10.015; 3/1/11, 7/15/11, 12/1/11  
definitions and general provisions; 2 CSR 90-10.001; 3/1/11, 7/15/11, 12/1/11  
disciplinary action; 2 CSR 90-10.165; 3/1/11  
formal hearing; 2 CSR 90-10.145; 3/1/11  
hearing officer; 2 CSR 90-10.150; 3/1/11  
informal hearing; 2 CSR 90-10.140; 3/1/11  
inspection authority—duties; 2 CSR 90-10.011; 3/1/11, 7/15/11, 12/1/11  
installation requirements; 2 CSR 90-10.013; 3/1/11, 7/15/11, 12/1/11

#### NFPA

Manual No. 54, *National Fuel Gas Code*; 2 CSR 90-10.020; 3/1/11, 7/15/11, 12/1/11  
Manual No. 58, *Storage and Handling of Liquefied Petroleum Gases*; 2 CSR 90-10.040; 3/1/11, 7/15/11, 12/1/11  
Manual No. 59, *LP Gases at Utility Gas Plants*; 2 CSR 90-10.060; 3/1/11, 7/15/11, 12/1/11  
Manual No. 501A, *Manufactured Home Installations*; 2 CSR 90-10.070; 3/1/11, 7/15/11, 12/1/11  
Manual No. 1192, Chapter 5, *Standard for Recreational Vehicles*; 2 CSR 90-10.090; 3/1/11, 7/15/11, 12/1/11  
proceedings; 2 CSR 90-10.170; 3/1/11  
prohibition on ex parte communications; 2 CSR 90-10.185; 3/1/11  
registration—training; 2 CSR 90-10.012; 3/1/11, 7/15/11, 12/1/11  
reporting of odorized LP-gas release, fire, or explosion; 2 CSR 90-10.120; 3/1/11, 7/15/11, 12/1/11  
requests for hearings; 2 CSR 90-10.155; 3/1/11  
settlements; 2 CSR 90-10.175; 3/1/11  
storage; 2 CSR 90-10.014; 3/1/11, 7/15/11, 12/1/11  
transmittal of record and recommendation to the commission; 2 CSR 90-10.180; 3/1/11

#### PUBLIC SERVICE COMMISSION

ex parte and extra-record communications; 4 CSR 240-4.020; 11/1/11

#### REAL ESTATE APPRAISERS

applications for certification and licensure; 20 CSR 2245-3.010; 7/15/11, 11/1/11  
case study courses; 20 CSR 2245-6.040; 7/15/11, 11/1/11  
examination and education requirements; 20 CSR 2245-6.015; 7/15/11, 12/1/11  
general organization; 20 CSR 2245-1.010; 7/15/11, 11/1/11  
inactive status; 20 CSR 2245-4.025; 7/15/11, 11/1/11  
instructor approval; 20 CSR 2245-8.030; 7/15/11, 11/1/11  
requirements; 20 CSR 2245-8.010; 7/15/11, 11/1/11

#### REAL ESTATE COMMISSION, MISSOURI

branch offices; 20 CSR 2250-8.030; 12/1/11  
deposits to escrow or trust account; 20 CSR 2250-8.120; 12/1/11  
general requirements; 20 CSR 2250-7.070; 12/1/11  
partners, association, or corporation license; 20 CSR 2250-4.070; 12/1/11

#### RETIREMENT SYSTEMS

county employees' retirement fund  
payment of benefits; 16 CSR 50-2.035; 10/3/11  
local government employees' retirement system, Missouri (LAGERS)  
actuarial assumptions; 16 CSR 20-4.010; 11/1/11  
disability retirement applications and other relief; 16 CSR 20-2.085; 11/1/11  
public school retirement system of Missouri, the  
membership service credit; 16 CSR 10-6.040; 8/1/11, 12/1/11  
payment for reinstatement and credit purchases; 16 CSR 10-4.012; 8/1/11, 12/1/11  
reinstatement and credit purchases  
16 CSR 10-4.014; 8/1/11, 12/1/11  
16 CSR 10-6.045; 8/1/11, 12/1/11

#### SOIL AND WATER DISTRICTS COMMISSION

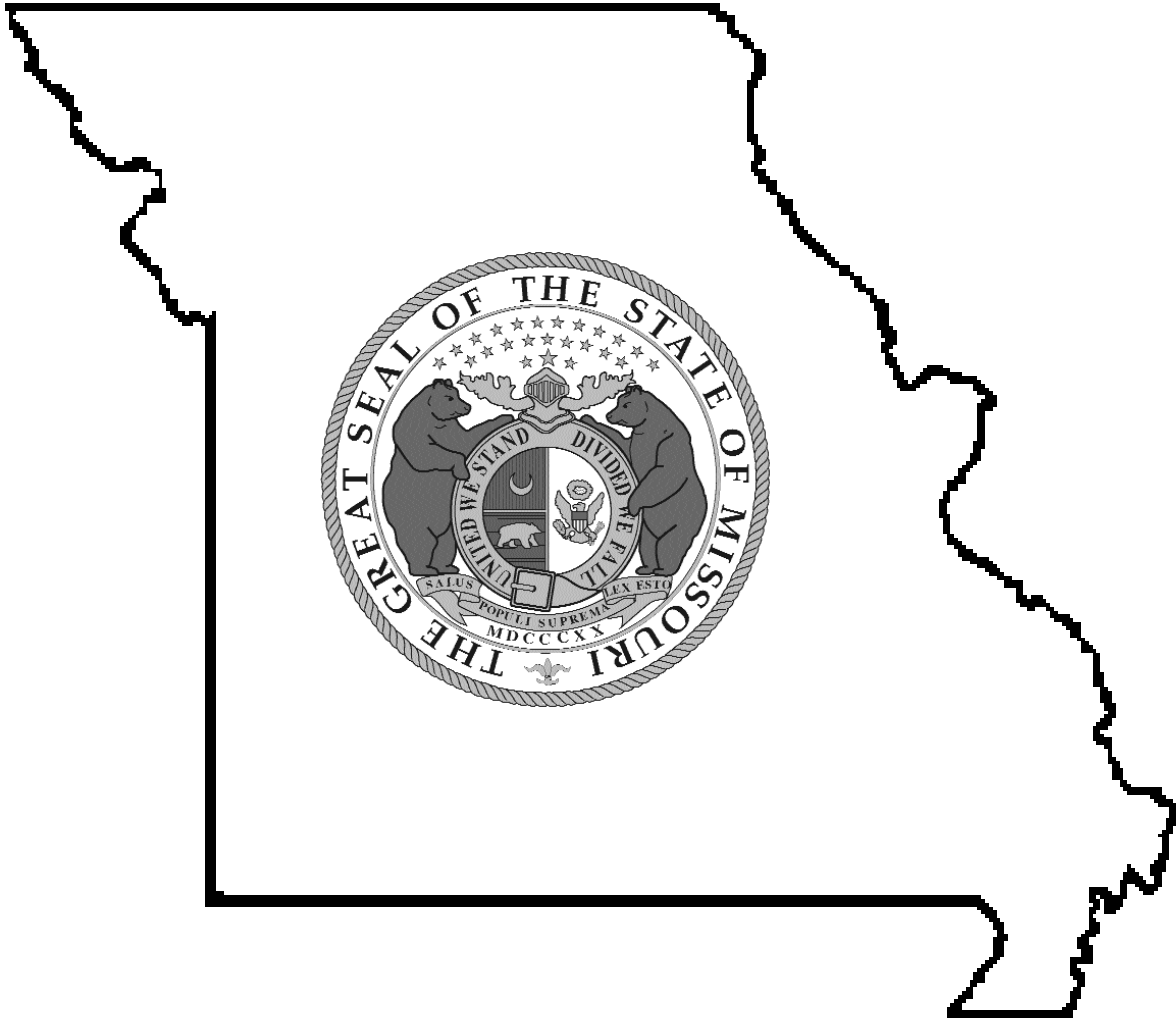
allocation of funds; 10 CSR 70-5.010; 2/1/10  
application and eligibility for funds; 10 CSR 70-5.020; 9/1/09  
apportionment of funds; 10 CSR 70-5.010; 9/1/09  
commission administration of the cost-share program; 10 CSR 70-5.060; 9/1/09, 2/1/10  
conservation equipment incentive program; 10 CSR 70-9.010; 9/15/08  
cost-share rates and reimbursement procedures; 10 CSR 70-5.040; 9/1/09, 2/1/10  
definitions; 10 CSR 70-4.010; 2/1/10  
design, layout and construction of proposed practices; operation and maintenance; 10 CSR 70-5.030; 9/1/09  
district administration of the cost-share program; 10 CSR 70-5.050; 9/1/09, 2/1/10

#### TAX

accrual bedding reporting; 12 CSR 10-4.628; 9/1/11  
animal bedding—exemption; 12 CSR 10-3.894; 9/1/11  
annual adjusted rate of interest; 12 CSR 10-41.010; 12/1/11  
collateral requirements for nonstate funds; 12 CSR 10-13.030; 11/15/11

# RULEMAKING 1-2-3

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